

**An investigation into staff
experiences of working in the
community with hard to reach
severely mentally ill people.**

Vimala Uttarkar

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Abstract

Several studies have evaluated the effectiveness of community mental health services by measuring economic viability and client outcomes. Whilst some surveys have emphasized the pressures experienced by mental health staff in the community, none have elicited details of these pressures, how staff cope and what qualities and structures might be more or less effective. This study attempts to understand how mental health staff deal with the emotional impact of working with people suffering from severe mental illness in the community.

Observation of and interviews with staff from mental health teams in the community were carried out. Using grounded theory, emerging themes were clustered together and ideas drawn from systems and psychoanalytical theories were used to develop an understanding of how the teams worked and whether there were particular personal attributes that staff possessed which help them carry out such work and, what organisational structures enhance these qualities. Although an important measure of the competence and efficiency of these teams is their impact on their patients, this study does not focus on patient outcomes nor does it elaborately scrutinise the overall effectiveness of the teams; instead it focuses on staff and attempts to explore what facilitates them to cope with the emotional demands of this work.

Three different types of community teams were studied; an Outreach Team for Homeless Mentally Ill people (OHT), an Assertive Outreach Team [AOT], and a 'standard' Community Mental Health Team (CMHT). Clients of the three teams varied in the severity of their illnesses and thus the intensity of their needs. The specific skills needed were found to be different in the three teams: those in the OHT were persistence and tolerance of high levels of risk with their most chaotic and damaged clients; in the AOT it was the ability to share skills in the team and develop all the professional skills necessary to maintain people out of hospital; whilst in the CMHT it was the ability to cope with working individually with larger client caseloads, to organise and coordinate community resources.

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Contents

Abstract.....	2
Acknowledgements.....	3
Contents	4
Chapter 1: Background and Literature.....	7
Introduction	7
Background	7
Origins of the treatment and policy development in Mental Illness	9
This Research	12
Literature Review	14
Empirical Literature on Community Treatments for Mental illness	14
Literature focussing on staff.....	17
Description of terms and concepts	19
a) Mental Illness.....	19
b) Hospital versus Community	22
c) Recent Legislation and Policy	24
d) Risks	26
e) Systems Psychodynamics Model	27
The Questions	42
Chapter 2: Focus, Design and Methodology	43
Focus	43
Design.....	43
Choice of Methods: co-relativity of paradigms.....	45
Observations	46
Interviews	50
Ethical considerations	52
Survey and selection of teams.....	54
Data Analysis.....	58
Theoretical Influences in data analysis.....	59
Strengths, Limitations and Applications	63
Presentation/ Arrangement of Findings & Interpretations	65
Chapter 3: The Outreach Homeless Team.....	66
Introduction	66
Emerging Themes.....	68
Team Meetings	68
Nature of Clients	69
Treatment Interventions	72
Support for staff.....	74
Visit Observation.....	76
Staff Role	77
Staff Skills	78
Counter-transference	80
Staff interviews	83
Nature of the work.....	84
Staff Qualities	86
Stressors and Supports.....	88
Inferences and Organisational Themes.....	91
The Team as a Social System	91
The Primary Task.....	92
Basic assumptions	93
Social Defences	94
Projections, projective identification, denial and splitting.....	95
Conclusion	97
Chapter 4: The Assertive Outreach team.....	98
Introduction	98
Emerging Themes.....	100

Team meetings	101
Team Approach.....	102
Treatment interventions	104
Support for staff.....	106
Visit Observations	109
Staff role	109
Staff Skills	111
Countertransference	114
Staff Interviews	116
Patient Characteristics	117
Staff Qualities.....	118
Stressors and Supports.....	120
Inferences and Organisational themes.....	124
The Team as a Social System	124
Primary Task	125
Basic Assumptions.....	126
Social Defences	126
Projection, projective identification, splitting and avoidance.....	127
Conclusion	129
Chapter 5: The Community Mental Health Team.....	130
Introduction	130
Emerging Themes.....	132
Team Meetings	132
Nature of Clients	133
Treatment interventions	136
Support for staff.....	139
Visit Observations	141
Staff Role	142
Patient Characteristics	145
Countertransference	147
Staff Interviews	150
Staff Qualities.....	151
Stressors and Supports.....	152
Risks and Audits	154
Inferences and Organisational themes.....	156
The Team as a Social System	156
Primary Task	157
Basic Assumptions.....	158
Social Defences	159
Denial, splitting, projections and projective identification.....	160
Conclusion	162
Chapter 6: Comparison of Themes and Discussions.....	163
Introduction	163
The systems context	164
Care Pathways for people with Mental Illness	166
Pattern of participation in this study	169
Membership	170
Accountability	172
Management	175
Care Pathways and decision making.....	177
Comparison of core data from each team	179
Themes in the team meetings.....	180
Nature of Clients/Team Approach.....	181
Treatment Interventions	182
Staff Support	184
Themes in the observations of visits.....	184
Staff Roles.....	186
Staff Skills/Patient Characteristics	186
Counter transference	187
Themes in staff interviews.....	188

Staff Qualities	188
Stressors and Supports.....	189
Comparing discussions.....	190
Conclusions	194
Chapter 7: Conclusions and Recommendations	197
Introduction	197
Overview of Findings	197
Reflections	200
Questions that could not be answered	202
My learning	205
Recommendations for policy and practice.....	206
Appendices	211
Letter of Introduction to Teams.....	211
Team Information Questionnaire	212
Information Letter to Staff	214
Staff Participation Consent Form.....	215
Information Leaflet to Service users	216
List of Questions - Semi-structured Staff Interview	217
Guiding Questions for staff interviews:	217
List of questions for Managers	218
Guiding Questions for interviews with managers:	218
Data Analysis table	219
Glossary	220
References	222

Tables & Charts:

Table 2.1	Data collected in this Study	57
Table 3-1	Observation Notes, Commentary & themes.....	81
Table 6-1	Staffing and participation data from the three teams.....	170
Table 6-2	Emergent Themes from Data Analysis.....	179
Table 6-3	Differences in Team Make-up	180
Table 6-4	Meetings by Team	181
Table 6-5	Client Attendance at Appointments with Staff	185
Table 6-6	Comparison of Team Objectives & Primary Tasks.....	192
Chart 6-1	Organisation of Mental Health Services	165
Chart 6-2	Care Pathway of the Mentally Ill Patient.....	167

Chapter 1:

Background and Literature

Introduction

In this chapter, I will set out the background to this study, the historical perspectives of the treatment of mental illness and their influence on the development of policy in Britain. I will then describe how I came to choose the topic and carry out a comprehensive review of the literature including a consideration of relevant research and other articles published since the 90s. This is followed by a brief description of the terms and the systems-psychoanalytical concepts I have used to understand the main findings which are described in the later chapters. I will end this chapter with the questions that were formulated and were found to have no answers in existing literature.

Background

Britain has followed the recent international trend of moving the treatment of mental illness into the community. Since the 1950's the number of psychiatric beds in Britain has fallen by almost two thirds (Thorncroft and Strathdee 1994) and treating and caring for the severely mentally ill is now mainly in the community. As elsewhere in the world, this has been based on beliefs that it is more therapeutic, humane and would result in a better quality of life for them, apart from the economic attractions of it being more cost-effective than running large hospital wards. However, as far back as the 70s, researchers like Wing (1996) deliberated on the multiple sources of disability such as the primary symptoms, patients' individual reactions to these symptoms and external factors such as stigma, discrimination and poverty, which required a comprehensive service that addressed their medical, psychological and social needs. As Hinshelwood (Hinshelwood, R.D. and Skogstad, W. 2000) says, *'An approach to someone with a mental illness must be to approach a person whose suffering is in some sense located in their personhood.'*

(p157) Are modern services equipped for this holistic response or are they really too discouraged and demoralised by the bleakness of the situation? Bachrach (1996) pointed out that *'Our imagination and our creativity, to say nothing of our financial resources, have not always been equal to the challenge of responding to the varied treatment needs of mentally ill people living in the community.'* (p6). Hopelessly fragmented services have shunted a number of people into ill-funded, ill-monitored mini-institutions, while leaving others either unable to maintain independent accommodation and thus becoming homeless or demonstrating a persistent dependence on hospitals resulting in the revolving-door pattern of admissions. Whilst engaged in an attempt to normalise their experiences, services are also simply not ready to deal with their attempts to adopt normal behaviour, such as experimenting with drugs or their struggle with poor standards of living at the fringes of society. A small fraction of this population in the community, refuse to engage with services. As Segal (1986) suggested, people suffering with psychosis project their terror, badness, confusion and fragmentation into the staff and thus perceive them as terrifying figures with whom they do not want to have contact. Their perfunctory treatment by the system and the staff has been the subject of growing literature. But what of the staff who make up these services, can they rise to these demands and persist in delivering services and advocating on their clients' behalf, as Hinshelwood (Hinshelwood, R.D. and Skogstad, W. 2000) further points out, *'..... . to be devoted towards bringing to life those aspects of the person which seem to have succumbed, in the death of the mind that madness is'* (ibid). 150 years earlier Main (1957) had already demonstrated the effects of these demands on hospital workers. Nathan (1998) suggested that each staff member in the community has the full recognition that they themselves have the responsibility for the client's situation. Going beyond a simplistic blaming of policy makers and the lack of resources, how do practitioners defend themselves against these demands? What structures help them if, as Hinshelwood (1998) urges, the quality of support for staff is crucial in facilitating their continuing work in a thoughtful and reflective manner. The question therefore is: How can the workers in such teams contain the emotional distress stirred up by their

experiences and avoid destructive consequences both for themselves and the work they do? This research is an attempt to answer this question.

Origins of the treatment and policy development in Mental Illness

The nineteenth century saw the development of a gradual benevolence in attitudes towards mental illness, bringing in the moral treatment which changed the status of mentally unstable people from prisoners to that of patients. This resulted in an extensive asylum movement to ensure that they received proper treatment. In the next 100 years patients and practitioners were moved into enclosed and often remote institutional spaces with few opportunities for therapeutic optimism. The Lunacy Act of 1890 only permitted asylums to take in people who had been certified through a cumbersome legal process, turning them into institutions for the incarceration of those considered beyond hope. Acknowledging the negative effect of this practice, the Royal Commission on Lunacy and Mental Disorder in 1926 stated that insanity could be treated no less effectively than any bodily disease and so should be dealt with along modern public health lines. This was followed by the Local Government Act of 1929 which stipulated that local authorities should make provision for the establishment of psychiatric outpatient clinics at general and mental hospitals. The Mental Treatment Act 1930 made mental hygiene a personal responsibility and a national objective. Despite these initiatives, there were few such outpatient clinics and even fewer observation wards in general hospitals. Patients were still either discharged or committed to mental hospitals where therapeutic interventions were rare as were the use of the emerging physical treatments. The Second World War shifted the focus of developmental ideas about care in psychiatry away from the long-term hospitals to the study of psychologically important aspects of group life to enhance the fit between the person and the organisation. The 50s saw the systematic introduction of these techniques of administrative therapy, in combination with chemotherapy and psychoanalytically-inspired individual therapy, leading to the unlocking of the doors of these mental institutions. The discovery of genuinely effective psychotropic drugs offered the possibility of improvement in

symptoms, challenging the need for lifelong confinement. A view was also evolving that these long periods of institutionalisation stripped away the personality and the identity of the patients. In 1961, Goffman described them as *'total institutions symbolised by the barrier to social intercourse with the outside and to departure that is built right into the physical plant, such as locked doors, high walls, barbed wire, -----'* (p 4). In writing about how *'Mental patients can find themselves crushed by the weight of a service ideal that eases life for the rest of us'*, he commented extensively on the systematic institutionalisation of people into the role of mental patients and the importance of holding on to this notion of perpetuating the patient role and legitimising the existence of staff to plan for all their essential needs and have their full day scheduled for them. Bott Spillius (1990), from her study of a similar institution in North London between 1956 and 1972, found that relatives sought acknowledgement that patients' behaviour was intolerable because of their illness so that admission into a hospital laid the responsibility for the care, control and treatment squarely on the doctor and the hospital. She also confirmed the view *'that control and care operates in the interests of society and that only treatment operates in the interests of the patient.'* (p598). Wing (1996) argued that reforms to counter the symptoms of institutionalism such as apathy, resignation and depersonalisation were difficult to maintain, and it was easier to do away with the institutions and re-invest the scarce resources into more effective forms of provision. The post-war move towards the welfare state had introduced social reforms in the form of public housing and a comprehensive system of primary health care, enabling treatment outside of custodial care. The Mental Health Act 1959, allowed informal admissions of patients to mental hospitals for the first time, as well as facilitating periodic involuntary admission, and opened up venues for care in the community by encouraging liaison between health and social services. Enoch Powell's Hospital Plan (**Ministry of Health 1962**) envisaged the closure of a majority of the mental hospitals within the next 15 years, and laid out a plan for developing a variety of units, mostly provided by district general hospitals and local authority provisions. This modernisation of psychiatry through short hospital interventions and minimal legal formalism followed by aftercare in the community through outpatient clinics, social support, sheltered housing and a wide network of other

services with psychiatric expertise, including voluntary organisations, received further impetus from the Mental Health Act 1983.

The following twenty years saw mental health services encompassing ever wider issues and more people seeking help voluntarily even as the budgets were shrinking. Mental health provision was a high cost service demanding a considerable chunk of the NHS budget (Raftery 1991, Hollingsworth 1992 & Sullivan 1996). Much of this money was going towards the repairs and renovations of old institutions at the cost of direct care for patients. Taking this into consideration, along with the fact that there were increases in other public sector spending on social provision in the community through reforms in welfare benefits and social housing, legislation such as the NHS and Community Care Act 1990 was enacted to focus these services on those with severe and enduring mental illness in the community. However, increasing public dissatisfaction with care in the community and highly publicised cases of shocking failure and outrageous criminal offences, such as homicides of innocent members of public, drew attention to unrealistic policies and inadequate funding and resources. Similar phenomena were reported from other developed countries such as the US and Germany (Knudsen & Thornicroft 1996, Sharfstein, 2000). This moved the spotlight from caring for the mentally ill patient to safeguarding the community. Rose (2001) stated "*The little phrase 'care in the community patient' came to identify certain persons who, because illness had stripped them of their normal moral safeguards, posed a threat to the tranquillity, order and safety of 'the public'.*" (p 24). He goes on to say, "*The role of mental health professional is now less that of cure or care than of the administration of dangerous, damaged or desperate individuals across a complex institutional field comprising institutions of various levels of security . . .*" (*ibid*). Other researchers such as Swanson et al (2000) were publishing trial results about ways of minimising the risks of violent behaviour by mentally ill people and advocating for powers to enforce treatments in the community. This pre-occupation with risk has engendered a growing demand for extended coercive powers to secure drug compliance and other protective conditions in the community, culminating in the new Mental Health Act 2007 which emphasises enforced community treatment orders.

This Research

My interest in this subject derives from having directly worked with the severely mentally ill for over 20 years. I started as a social worker on a long-stay ward in a large mental hospital and then moved to manage a specialist mental health team for a minority ethnic community. I went on to manage one community mental health team initially and gradually took over responsibility for a number of specialist multi-disciplinary statutory teams working with specific aspects of mental health rehabilitation and resettlement in the community. I was involved in closing down a large hospital and implementing reprovision in the community. I currently head a voluntary organisation which offers community care to people who have forensic mental health issues.

Thus I started work with adults of working age who had had psychosis for more than two years and in many cases had been continuously psychotic for much longer. Many had become ill as adults after having developed some independent skills of living but these skills had become obscured by the psychotic processes that took over their lives. Many years of working with this client group brought an awareness of the problems of a small number of people whose psychosis interfered with their ability to engage in interactions with people around them, making them withdrawn and rejecting of their social environments.

O'Shaughnessy (1992) points out that: *'In that part of the personality which is psychotic (which to a greater or lesser extent is in everybody) the mind is neither thinking nor perceiving'* (p92), so that work with these clients demands resilience and an ability to work with diminishing returns, as any initial improvements are usually followed by long periods of stabilisation at best and slow deterioration at worst.

Moving into management brought responsibilities for other staff and their work– and a realisation that supervising staff who did this work was even more demanding. As Main (1957), puts it:

' . . with patients who do not get better, or who even get worse in spite of long devoted care, the major strain may arise. Those who attend the patient are then pleased neither with him nor with themselves, and the quality of their concern for him alters accordingly, with consequences that can be severe for both patient and attendants.' (p 12)

Despite understanding that the rejecting/withdrawing behaviours of clients was a reaction to the alien and involuntary thoughts which force themselves into their minds, frightening them, so that their mental processes are completely preoccupied with getting rid of these thoughts, rather than furthering the process of assimilation and integration into society through engagement, some staff found it unbearable to work with them, whereas others engaged well with this group of clients. Having perceived the existence of this difference, I became interested in exploring it further to better understand and evidence the current thinking on the everyday experiences and unconscious processes of these staff.

I moved further into management and thus became responsible for strategic planning of services and staffing requirements. My interest in understanding issues relating to staff who work in the community grew, particularly as I took on board Hinshelwood's (1998) point that:

' . . the awful task of containing the intolerable psychotic experience directly influences the organisation and enhances the problems of psychiatric institutions. Shared distress in the work arises from the nature of psychosis itself – or, perhaps we should say, from the nature of psychotic personalities themselves. Typically that distress is not formed or articulated in words; meaning itself gives way to an experience of meaninglessness. And this is contagious. It has a direct effect on others and, in fact, percolates through the whole system. Psychotic patients are very effective at having this non-verbal impact. Being a communication of meaninglessness, its communicative function is lost. It becomes merely an emotional impact, an unidentifiable experience. The impact is very unpleasant and by its nature very hard for staff to talk about in words.' (p18-19).

Do staff have an understanding of this impact? How do they cope with the fluctuating acceptance/rejection state of the client, while preserving the sense of personal integration and achievement that is required in order to continue doing this work? What internal processes facilitate staff to continue working with this client group in the community? What awareness do staff themselves have about all these issues?

Such were the questions I set out to answer in this research.

Literature Review

In searching for answers in the existing literature, I first of all looked at the relevant articles and publications which I had already come across during my many years in this work. Drawing on these key texts, I looked at the references quoted in them for additional study. This was further enhanced by searching key terminology using library catalogues and electronic data bases. What follows is a review of the literature relating to community alternatives in the treatment of mental illness. I have grouped them into those focussing on models of community treatment and those focussing on staff.

Empirical Literature on Community Treatments for Mental illness

A search of the literature within this area generated a large body of articles. I found that there is extensive description of quantitative studies and methodical reviews of the findings of those studies. They focussed on three main areas: comparison of models of services, the use of different therapeutic regimes and evaluation of their cost effectiveness.

Those focusing on the evaluation of services compared the effectiveness of different approaches such as Community Mental Health Teams (CMHT), assertive outreach teams (AOTs) and the Crisis and Home Treatment teams. In the late 70's, Stein and Test (1980) described their experience of setting up an assertive outreach service in Madison, Wisconsin in order to successfully engage into treatment even the most resistant and non

compliant patients in the community. This was followed over the next three decades by innumerable studies on different aspects of assertive outreach teams set up all over the world, a number of them were from Britain. Some reviewers of services and literature such as Galvin and McCarthy (1994) concluded that multidisciplinary community teams were not efficient in addressing all the requirements of mental health care in the community. However, Tyrer(2001) and Simmonds et al (2001) have published a number of papers defending community mental health teams (CMHTs) as more effective services in comparison with AOTs. Others such as Burns (2001a) urged policy makers to consider the growing variety of community services and focus on adequate resourcing and workable integration of these generic and specialist teams.

Studies which focussed on particular issues and studied the effectiveness of certain therapeutic regimes in these teams include the debates on the need for further research published by Tyrer & Creed (1995) reporting on research in a wide number of related topics. The Research and Development Directorate of the Department of Health has systematically collated many of these findings and facilitated the production of guidelines on various aspects of care through the National Institute for Clinical Excellence.

Rosenbeck et al (1998) described the effectiveness of Clozapine in treating treatment resistant psychosis. Ho, et al (1999) looked at psychosocial interventions for people with both mental illness and substance misuse. Yet others, like Garety et al (1997), have looked at the use of CBT in Community teams, whereas Wilkinson et al (2000) looked at self-reports of quality-of-life measures by patients being treated by CMHTs. Reports into homicides and suicides involving clients with mental illness demonstrated that they are often excluded from normal social life (Pilgrim & Rogers, 1996). Bellack et al (2007) looked at the effects of community care on patients by assessing their functioning, and concluded that outcomes can only be evaluated in part by 'clinical significance' as *'the field is limited by the absence of an objective gold standard of community functioning'* (p822). Mental health teams across the country are also engaged in assessing improvements elicited in patients during routine contacts by applying the Health of the Nation Outcome Scores [HoNOS] (Wing et al, 1996) at regular intervals, although there is as yet, no systematic evaluation of this data.

The late 80s-early 90s saw the publication of reports which systematically evaluated the reprovision of services following the gradual closure of Cane Hill Hospital (Pickard et al. 1989), published by the Sainsbury's Centre for Mental Health and the TAPS study by Leff (1993) and others about the closure of Friern Barnet and Claybury Hospitals. Taking into consideration that hospital beds are the most expensive component of mental health care, several articles have looked at the most efficient use of shrinking resources. Thornicroft and Strathdee (1994) had stated that:

'The debate on numbers of hospital beds should now be widened to include the contributions of agencies other than health providers, such as social services, housing, and voluntary organisations, which substantially reduce the need for inpatient care. In particular, long term NHS psychiatric beds are rapidly being replaced by places in smaller, private or not-for-profit residential care and nursing homes, which may be poorly regulated and not have 24-hour staffing.'

Thus emphasizing the need for community based teams to collaborate with these new providers to ensure their effective use. More recently, studies which have looked at the cost implications of these various services, include those of Knapp (1995) and Wilkinson et al (1995), reviewing several reports which found community based services to have economic advantage over hospital based care. Rosenbeck and Neal (1998) and Kent and Burns (2005), did systematic reviews of AOTs and concluded they are very cost effective in the long term. In addition, others such as Lehman et al (1999), and Coldwell & Bender (2007) found that assertive treatment in the community is the most cost effective way of dealing with homeless mentally ill people.

Killaspy et al (2005) compared AOTs and CMHTs and concluded that both were equally effective in reducing hospital admissions and controlling symptoms, however they appear not to have considered the patient profiles of these two very different types of teams. They point out that AOTs were the more expensive service due to low caseloads although they elicited better user satisfaction. This study, which I found after gathering the data, is particularly significant as it compared two of the teams which also took part in this research.

Literature focussing on staff

I would like to concentrate here on two clusters; firstly, reports of quantitative research using standardised questionnaires with staff in community teams and secondly, in addition to a few institutional observations, a number of articles by organisational consultants who write about their experiences of group supervision with teams that worked with the severely mentally ill in the community.

The Sainsbury's Centre for Mental Health [SCMH] undertook an extensive study of 60 CMHTs in the early 90s and concluded that on the whole, staff were over-extended and exhausted. It particularly identified social workers and consultant psychiatrists as being especially vulnerable. They also found that team managers did not carry overall responsibilities for key strategic and operational tasks and that these, in addition to organisational change and uncertainty, were significant sources of pressure for staff. However, staff who were clear about both theirs and their team's roles had higher job satisfaction and lower burnout. This was followed by a series of papers produced by the authors, Onyett, Muijen and others, about their findings and recommendations for improvement. Evans et al (2006) also had similar findings of the vulnerability of social workers in mental health teams. Researchers such as Repper (2000) identified the important role nurses have in promoting social inclusion; but pointed out that these teams produce high stress levels and have the potential for causing burnout.

McAdam and Wright (2005) reviewed literature on assertive outreach teams (AOT) and concluded that research findings concentrated on the importance of staff having the right personal attributes to work within AOTs. This complemented the government guidance regarding staff qualities (Department of Health 2000a), which included high energy levels, being a team player, the ability to creatively engage people and an understanding of the needs of service users in terms of age, gender and ethnicity. Williamson (2002) raises the question as to whether they perceive assertive outreach services to be a career option only for individuals with the right personal qualities. Ryan (1996) summarizes the different stressors on assertive outreach staff. He argues that mental health practitioners

are attacked by the media and public for not offering adequate protection. This would indicate that to recruit and retain staff with the necessary knowledge, skills and attributes, better investment in training, supervision and support needs to be made. Emphasizing the importance of staff qualities, some other studies, such as Killaspy et al (2006) have found that from a client's perspective, qualities such as respect, optimism, a belief in the value of a trusting relationship and the ability to manage the power imbalance are crucial. They found that although researchers and the current government appear to disagree on the level of importance of an individual's personal qualities and attitudes, the way that these are combined is important. Individual staff could improve their clinical knowledge and awareness of policy, but changes in attitudes or innate values would be extremely difficult.

In their pan-London studies, Billings et al (2003) compared job-satisfaction amongst staff in assertive outreach teams and CMHTs using the Maslach Burnout Inventory. They found that job satisfaction and work experiences for staff in AOTs were much better than for staff in CMHTs, where scores for staff burn-out indicators were much higher. Similarly Evans (2006) studied job satisfaction in mental health social workers. Other writers such as Paxton (1995), Huxley (1995) Chiesa, M (2000), Ovretveit (2001), and Holmes (2004) continue to write about the trials and tribulations of staff working in community teams from their own experiences, along with publications by bodies such as the Care Services Improvement Partnership (De Ponte et al, 2006) whose brief guidelines for CMHTs, complement the Policy Implementation Guidelines for MH (DH 2000c). The regular assessments of mental health service provision carried out by the Health Care Commission, continues to emphasize both the lack of training and support for staff increasing their stress and the lack of resources in the community to enable them to work effectively.

Organisational consultants have written about the psychoanalytical perspectives from their own experiences of the functions, processes and psychological defences in these teams. Following Menzies' (1959) seminal work in a general hospital, other psychoanalytical thinkers have commented on the defences and coping mechanisms that

staff use within mental health teams to manage the primitive anxieties evoked by work with people with severe mental illness. Stokes (1994) has applied Bion's theories on group behaviour, such as flight and fight, to staff in community teams, while Wykes (1995) writes about the toxicity of the service experienced by staff. She says that the untreatability of many of the clients, the complexity of the multidisciplinary approach and the lack of or the unworkability of management structures, together with the constant pressure of work and limited community resources – all contribute to the feeling that the work gets inside the individual worker in a manner that can feel dangerously malignant. Nathan (1998) further illustrates Menzies' concepts of fragmentation of the primary anxieties by staff. Hinshelwood (1998) argues that workers have to be able to get alongside the client and be able to extend this level of involvement with colleagues to enable reflective thinking about this very difficult work. The key to effective work by staff is a combination of their inherent qualities and the quality of support being offered to preserve their capacity for thinking and reflecting. Other well-known critics such as Halton, Nitsun, Obholtzer, Roberts and so on, are referred to in various places in this study.

Taking into consideration this bleak picture painted by the literature about the working life of mental health staff in the community, this research was set up to look at what exactly happens in these teams and what do staff draw upon to minimise emotional burnout and exhaustion.

Description of terms and concepts

This section describes the general terminology and major concepts that contextualise this research and form the basic framework upon which assumptions used in setting up the research and analysing the data are based.

a) Mental Illness

There is no agreed philosophy about the nature of mental illness or its cause. Interest in the origins and genesis of psychosis has stimulated research into a range of concepts

drawn from organic, social, and psychological theories. These various theoretical approaches to psychosis have led to the development of different models of treatment. For the purposes of this study I believe it is sufficient to only consider those that deal with the severe end of the spectrum of mental illness.

As attitudes moved from custody to care, the institutional-medical model emerged with its focus on physical treatments, including containment in hospitals to safeguard patients and others from an uncontrollable illness. However, the medical model emphasized symptoms and problem behaviours. The effects of this colluded with the stigmatising, labelling and dehumanising of patients. Questioning this view of mental illness and the philosophy of enforced care for the mentally ill, critics such as Goffman (1961) urged that *'the discreteness of the entity in which the disorder exists is questionable.'* He further quotes Szasz's arguments about the difficulties of discerning the difference between *'he is wrong'* and *'he is mentally ill'* so that an opinion about a person's mental health is based on a value judgement regarding their inferior status and hence they can be easily labelled as being mentally ill. However, he concedes that:

'In psychiatry there is a formal effort to act as if the issue is treatment, not moral judgement, but this is not consistently maintained. Ethical neutrality is indeed difficult to sustain in psychiatry, because the patient's disorder is intrinsically related to his acting in a way that causes offence to witnesses.' (p364).

At the same time that this anti-psychiatric movement appeared, drugs began to be developed which were effective in significantly suppressing abnormal behaviours. This led to a care in the community based medical model which focussed on using the new drugs to control and contain the illness without confinement in hospitals. But for patients, life in the community required social skills for activities of day to day living. The disabilities caused by severe mental illness deeply affected these skills, so that they required intense social support and care. The social model of care highlights patients' strengths and skills rather than their weaknesses and symptoms. It facilitates de-stigmatisation and rehabilitation. Alongside the medical and social model, the psychological model has been developing therapeutic approaches such as behaviour

modification, systemic and family therapies and cognitive behavioural approaches to address the effects of severe psychosis. All these models of care are directed towards achieving stability and a level of functioning rather than total cure. The contemporary view of psychosis is of a '*multideterminate*' phenomenon, emerging in a vulnerable self from a complex network of biogenetic, relational and environmental factors. This bio-psychosocial model of treatment has inherent conflicts in its philosophies of practice between control versus care and management versus empowerment – these tensions have pronounced effects on professionals as they find and constantly re-find appropriate balances between these approaches to respond to the changing needs of these patients.

It is generally agreed that there are few aspects of their lives that clients with SMI do not need help with. Wright et al (2003) found that staff identified 10 most common focus categories in their primary contact with the patient, this included engagement (21.3%), medication (17.1%), specific mental health intervention (15.1%), housing (7.5%), occupation and leisure (7.6%), daily living skills (7.0%), finance (5.1%), help with carers/significant others (2.9%), physical health (2%) and the criminal justice system (1%). An awareness of these varied areas of need has resulted in bringing together a number of different professions into single teams to respond to them. However, the training received by each practitioner is different, inculcating a different professional ethos in each discipline. Raftery (1991) and Tyrer (1995) amongst others pointed out that the combination of beliefs and attitudes within each discipline is such that when workers are put together as qualified professionals to work in a team in the community, a potentially explosive mixture is produced. For example, psychiatrists' concerns to formulate a diagnosis based on the signs and symptoms of the illness as the very basis of their work of prescribing treatment, is in stark contrast with the social model which, as Carpenter and Barnes (2001) point out, '*is concerned with the individual service user in the context of his or her family and social relationships and the communities in which they live, and aims to alleviate the socio-economic causes of mental ill health.*' (p420) and views the diagnostic label as dehumanising patients and even totally disabling them. These differences demand thoughtful reflection by staff so that they are not so preoccupied with these issues that they limit their clients' recovery. Staff need to bear in mind the internal

conflicts of their clients that render them unable to engage and address their desperate need to be held in a manner that enables them to feel safe from their own destructive impulses.

b) Hospital versus Community

Goffman (1961) described the mental hospital setting as a '*holding station*'; barely successful in attempting to create an environment which could contain and reintegrate the feelings that were felt to be unmanageable on the outside. Within a ward setting, the limited physical space and the availability in close proximity of both people in the form of other patients and staff and the means of sedation, act as barriers against personalising rejecting behaviours. However, these same behaviours can feel like personal attacks experienced as quite threatening during visits to clients in the community, where neither the physical containment nor the containing resources are available. Work in the community demands skills of self-dependence and an understanding of all the other systems that could influence the state of the client's mind. In the community the importance of clinical knowledge and skills, the policies that govern the work as well as personal attributes and the support from the '*team-in-the-mind*' (as described below), are extremely important in order to contain the effects that unmanageable behaviours of the clients have upon the workers' own abilities to tolerate such onslaughts and to retain their capacity to think and act in order to offer the required care and support to these clients.

The risks inherent in the current system of mental health services and the hazards they pose to individual workers have not been well thought through. Though they are expressly identified, there is very little evidence that much consideration has gone into how issues like staff burn-out may be reduced and what effects this may have on the patients. In setting up community services there has been little contemplation given to the awareness that, even within professions such as social work where fieldwork in the community is a major part of the traditional professional role, ill-defined statutory obligations and demands for constant justification produce high levels of anxiety which have often resulted in anti-task activities such as fight and flight, expressed in the form of

high staff turnover, confrontations and strikes (Stokes 1994). Specifically in the mental health field, one could argue that staff suffer seriously, not from any cracks in their individual work ethic, but often from too great an expectation of themselves – and burn themselves out in trying to achieve these high aspirations (Main 1957). Menzies (1959) pointed out that the patriarchal system of the general hospital which contained staff and patients evoked high anxieties, creating anti-task responses such as dependency, and not thinking for oneself, stultifying patients' recovery and promulgating staff alienation from patients that lead to dissatisfaction with the work. The pointedly naïve assumption in Healy's (1992) definition of integration of mental health services as developing and maintaining a seamless network of psychiatric inpatient and community services, ignores the boundaries and ethos of the functions and professions that are brought together. Community mental health teams with workers from different disciplines working in an integrated way started springing up irregularly across the country. Initially these teams did not have distinct boundaries with regard to the number and kind of clients they could work with and, more damagingly, they did not have well-defined staff roles. Re-creating the hospital team with its hierarchies, including staff who had hitherto been completely dependent on the medical chain of command and were now suddenly expected to make decisions independently while visiting patients in the community along with other community staff (social work) who had not been subject to these hierarchies, was full of difficulties.

Commenting on the kind of staff needed to work in integrated teams, Huxley (1995) pointed out that *'we need people with flexibility in attitude, capacity to learn new work, preparedness to change, and ability to work with and support others'* (p326). Paxton (1995) pointed out the diverse expectations held of these teams as:

'... they are expected to implement government policy, resolve tensions between agencies and disciplines, supply services to primary care teams, act as gatekeepers to secondary care, function as both purchasers and providers of mental health care, and be a panacea for the range of mental health problems',

further stressing

'... that multidisciplinary community teams usually lead to unfocussed, inefficient and low quality services; with team members left deskilled, confused and demoralised' (p331).

It was emphasized that the distortions found in the old large institutions recurred and became exaggerated with the establishment of teams in the community without producing much improvement in the quality of life of the patients. Onyett et al (1994), in a survey of the organisation and operation of CMHTs, found tentative evidence for lower turnover of staff among less medically dominated teams. Such teams were few and far between, so that, in a majority of the teams, staff morale had plummeted and the effects of this was very evident in the service being offered to clients who were falling through the service nets. Several inquiries, such as that into the care of Christopher Clunis, (Ritchie, Dick, Lingham, 1994) reported on the "catalogue of failure and missed opportunity". Media reports of continuing fatal incidents and inquiry reports were generating the public view that *'Care in the Community'* for the mentally ill was failing miserably as it offered inadequate, indistinct and infrequent support to highly disturbed and damaged patients.

c) Recent Legislation and Policy

The Government was increasingly focusing attention on developing a framework for the comprehensive care and treatment of mental illness in the community. Community Care: Agenda for Action (Griffiths 1988) reviewed the care for mentally ill people in the community by introducing care managers in Social Services whilst highlighting the inadequacy of existing resources to respond to the escalating demands for relevant services in the community. The NHS and Community Care Act 1990 consolidated and increased the scope of the community facilities that the statutory services could provide. Poor follow up and lack of the coordination of care in the community for former patients led to the introduction of the care programme approach (CPA) (Department of Health 1990). The CPA emphasized holistic care by ensuring that patients received help from different services and staff; and that this care was coordinated by a single professional staff member allocated to each patient to act as their care coordinator (CC) and to hold

responsibility for coordinating these services and facilitating the implementation and regular reviews of the care plan. The joint implementation of the Care Management and the CPA through integrated budgets was made possible by Section 13 of the Local Government Act 1972 and latterly Section 28 of the Health Act 1999.

Decreasing budgets and increasing demands led to development of the National Service Framework (NSF) for Mental Health (DH 1999) which laid down eligibility criteria to prioritise service provision for those suffering from severe and enduring mental illness (SMI) and set clear standards for achieving uniform and effective service provision in the community. This was followed by the Policy Implementation Guidelines for NSF in Mental Health (DH 2000c), clarifying the government's vision of the range of services that should be made available locally to enable people with SMI to live in the community. An assortment of services was established to supplement the work of the CMHTs, including assertive outreach teams [AOTs], along the lines of similar teams in the United States and Australia. The objective of these teams was to focus on the small group of clients who disengaged with services as soon as they were discharged from hospital by concentrating on establishing and maintaining contact with them and eventually helping them to engage with mainstream CMHT services. The government, in its bid to empower patients, declared that one of the primary aims of its policy, outlined in the NHS Plan (DH, 2000) and reiterated in all subsequent policy and guidance, is to ensure that services are *'shaped around the convenience and concerns of patients'* emphasizing that *'Quality is not restricted to clinical aspects of care, but includes quality of life and the whole patient experience'*. (p15). Whilst increasing the range of services, there was also more focus on emphasising and managing the risks inherent in providing community alternatives for the treatment of mental illness - a difficult balance to achieve - culminating in the Mental Health Act 2007 which requires the development of effective independent advocacy for patients while giving professionals the powers to treat patients compulsorily in their homes. All-in-all, these developments are leading towards increasing proceduralisation of the care of the mentally ill.

d) Risks

Pilgrim and Rogers (1996) argue that, in psychiatry, risk is a twofold concept – those posed by services to patients and those posed by patients. In describing the risks posed by services they include wrongful detentions, increased surveillance and the loss of personal privacy, as well as the loss of social resources such as housing, employment and support networks due to the demands made by hospitalisation or regular attendance for treatments. In addition, they point to the iatrogenic risk of permanent damage caused by drugs and abusive, uncaring and ill-qualified staff. In assessing the risks posed by patients, they point out that the reliability of risk assessments as accurate predictors of possible hazards is highly controversial. Monaghan and Steadman (2000), who reviewed five major studies, found accuracy rates of only one in three predictions of violent behaviour over several years, even for hospitalised patients with past history of violence. Langan (2007) reveals *'Buchanan and Leese's (2001) meta-analysis indicated that a minimum of six people would be incorrectly identified as dangerous for every person correctly identified'* (p3). She emphasises that *'The approach to risk discernible in practice is positivist with risk reified and viewed as objective, value-free and amenable to the application of rational approaches designed to predict and prevent its occurrence.'* (*ibid*). The National Service Framework for Mental Health (DH 1999) states that practitioners need to be competent to assess risk and manage violence and ensure safety. The DH (2007) publication on Best Practice in Managing Risk and the NICE Guidelines also advocate this concept that staff competency depends on achieving the unrealistic expectations of risk elimination. Staff work responsibly when they do so with an awareness of these factors, as Argyris and Schon (1974) point out, *'The practitioner must be willing to take responsibility for what he does. In actual situations of practice, the costs of failure are likely to be high'*. (p162). The dangers inherent in working in the community include the fact that staff do not know in advance what they will face with a client on a day-to-day basis. In considering this, Foster (1998c, p89) points out that:

'People with psychotic illness are prone to split off awareness of things that feel uncomfortable; they then become available receptacles for the projections of

others. This unconscious dynamic of splitting off and projecting feelings of rage and murderousness increases the disturbance of those who are already unstable, and increases the likelihood that those who are prone to violence will act violently.'

According to psychoanalytical views of working with severe mental illness, it is more likely that work within transference relationships with clients may pose difficulties as relationships may be brittle and easily destroyed, damaging the delicate balance of their interactions. In a situation where the mind is neither thinking nor perceiving, if the acute feelings of fragmentation are acted out, there is very little physical containment available in the community, resulting in self neglect and self harm or hitting out.

However, there is no recognition of the emotional distress such as shock, fear and depression induced in staff by their experiences with patients. Foster (1998 c) further emphasizes that staff may respond to these demands by developing systems of defences which include idealising the client and playing rescuer with an attempt to locate the destructiveness elsewhere, or playing bureaucrat and adhering strictly to rules and regulations so that they avoid patients and pass their responsibility elsewhere. These defences are neither clearly distinct nor mutually exclusive. In order to prevent them from becoming coercive and punitive or uncaring and irresponsible or collusive and lacking in boundaries, staff need access to training, information and a space to consciously reflect on these defences. In addition, policies and procedures that contribute to a sense of personal authority and encourage responsiveness to the changing needs of the client and provide a framework for thinking and analysing a situation, rather than laying blame on self and others, go a long way in minimising the risks inherent in this work.

e) Systems Psychodynamics Model

Fenichel (1954) observed that human beings create institutions to satisfy their innermost need to be social and to accomplish certain tasks but then these institutions become independent of external realities which in turn affect individuals in complex ways. There have been three perspectives of understanding human behaviour that have been

evolving at the Tavistock Clinic – open systems theories, psychoanalysis and group relations theory. In 1967, Miller and Rice published their seminal volume '*Systems of Organisation*' – which integrated these three disciplines into a single framework in an attempt to develop insights into the dynamics between individuals and their institutions. The systems designation refers to concepts borrowed from the open systems theory developed by Miller and Rice in the 50s, based on the work of Lewin (1948) and including the structural aspects of an organisational system, its design, its aims and objectives, the levels of authority within it, its work tasks and boundaries and processes. The psychodynamic aspect includes the recognition that work evokes primitive anxieties (Klein 1959) which influence group behaviour (Bion 1961) and mobilise systems of social defence (Jacques 1955 & Menzies 1959). The emerging perspective from the conjunction of these two distinct theories has been recognised as a distinct third entity and the term 'systems psychodynamics' was used for it. This conceptual framework has been used at the Tavistock to understand organisations in general and by consultants to help the 'person-in-a-setting' in effecting changes in the cultures, structures, and interrelationships of organisations through their individual members.

During data analysis, reflections on emerging themes were influenced by my understanding of the systems psychodynamic perspective encompassing ideas from both schools of thought. The following section contains brief descriptions of the concepts used, incorporating current thinking as a background to their expressed usage in the later chapters of this thesis.

The Unconscious

Freud postulated that certain hidden aspects of mental life greatly influence our day-to-day functioning. These unconscious workings of the mind cannot be directly observed but are only inferred. A large part of Freud's original work relates to the investigation into this unconscious part of the mind. He uses this term in two ways – in a common sense description and in a dynamic sense. The dynamic sense of unconscious thoughts is further differentiated into those that come into consciousness with relative ease and those that remain unconscious. The unconscious is governed by primary processes that are

not easily accessible to consciousness and may be so incompatible with the conscious experiences that there is emotionally charged refusal or resistance to acknowledge them.

Through her psychoanalytical work with children in the 1920s, Klein developed a theory of an inner world *'peopled by different characters personifying differentiated parts of self or aspects of the external world'* (Halton 1994, p13). Klein proposed that in the very earliest period of life, the infant relates to its environment and has both positive and negative experiences: he feels good about being fed, being kept warm and being responded to; on the other hand he is distressed by being left hungry, cold and anxious. The positive experiences are seen as coming from a 'good mother' who is loved, and the negative experiences come from a 'bad mother' who is hated. This process of splitting the primary care-giver results in the infant being in what Klein called the paranoid–schizoid position; schizoid because of the intra-psychic process of splitting; paranoid because of the deprivation and the perceived persecution as reprisal for the hatred. As the infant matures, it becomes aware that there is only one care-giver who is sometimes caring and sometimes seen as withholding – this realisation of ambivalence towards a single person whom the infant loves and hates, leads to feelings of guilt and remorse. Klein termed this the depressive position. Klein postulated that unlike the stages of infant development proposed by Freud, these are positions to which we oscillate back and forth throughout life.

Anxiety

In the earliest developmental stages, the infant experiences two opposing sets of feelings and impulses which stem from instinctual sources and are described by the constructs of the life instincts or libidinal forces and the death instincts or destructive forces. According to Freud, anxiety as the result of conflict arising from these instinctual tensions is inevitable and *'an inescapable fact of human existence; what matters is how it is dealt with and the adaptive or maladaptive nature of its resolution.'* (Yelloly 1980, p11)

Klein (1957) stated *'in my view the danger arising from the inner workings of the death instinct is the first cause of anxiety.'* (p29). Frustrations from internal and external persecuting objects at the pre-verbal stage cause this primitive anxiety which is often

reinforced by the infant's aggressive impulses. With maturation, the infant recognises the harm done by its aggressive impulses and fears the annihilation of the object, even as there is the realisation that the good and the bad object are one and the same. The increased capacity to integrate experiences leads to a shift of primary concern from survival of self to that of the loved object with a tendency for symbol formation and a move away from concrete thinking. This leads to depressive anxiety which is closely bound up with guilt for the damage caused to the object and a desire to make reparation. Thus persecutory anxiety is predominantly related to the annihilation of the ego, whereas depressive anxiety is related to the perceived harm done to the internal and external loved objects by these aggressive impulses. The source of these anxieties is essentially internal, though the real qualities of the environment do play a part in affirming the infant's experiences.

Splitting

In the paranoid-schizoid position, anxieties of a primitive nature threaten the immature ego and lead to the mobilisation of primitive defences such as splitting. The infant is preoccupied with the fulfilment of those instincts which give him pleasure and avoiding those that cause pain. The infantile ego lacks coherence and, when faced with persecutory anxiety, it strives to create rudimentary structures made up of idealised good objects which are kept separate from persecutory bad ones. Steiner (1988) points out that the infant's own impulses are also split, directing all his love towards the good object and all his hatred against the bad one. According to Klein (1959) *'The process of splitting changes in form and content as development progresses, but in some ways it is never entirely given up'* (p253). In adults with unresolved early conflicts leading to intense splitting in their relationship both with the external world and in their own internal world may become the basis for paranoid and schizophrenic illnesses. Applying this to staff, Halton (1994) points out that in the helping professions, there is a conscious effort to deny feelings of hatred or rejection of patients. These feelings are split off and projected into other groups and agencies which can then be somewhat openly criticized in an attempt towards self-idealisation.

Projection

'Externalisation of internal danger-situations is one of the ego's earliest methods of defence against anxiety' (Klein 1957, p32). In expelling dangerous substances out of the self and into the external object, the infant splits off parts of the ego - its impulses and feelings, and projects them into the mother who comes to be felt as the bad self so that much of the hatred against parts of the self is now directed towards the external object – Klein termed this projection. At this stage the infant's physical and psychic experiences are very intimately interwoven and the infant's thinking is concrete, with narcissistic object-relations created by projecting parts of the self into external objects. Rosenfeld (1988) recognised two uses for projective identification, one as a communication and the other for ridding the self of unwanted/unbearable parts of the self. Highly disturbed clients are likely to predominantly use this mode of unconscious communication to get rid of their unbearable pain. Acknowledging its effects on staff, Moylan (1994) points out that:

'When this predominates, it becomes very difficult for the group to find other ways of coping; it is almost impossible to think clearly, to locate the source of problems, and to find appropriate and creative solutions. In this situation, staff burn-out is also much more likely to become a problem' (p 56).

It is important for individual staff and teams to be alert to this and be able to distinguish their own feelings from those that they have picked up from their clients. A space and facility to do this and to put back the feelings where they belong is imperative if they are to continue working with this client group. This is a major consideration in psychoanalytical thinking about working with the mentally ill. How the teams in this study dealt with these issues is elaborated in the interpretation of the data for each of the team.

Counter-transference

'The state of mind where other people's feelings are experienced as one's own is called counter-transference' (Halton 1994, p16). Projective identification is an interpersonal interaction where the recipient of the projections responds to them as if these feelings

were their own. Freud identified the importance of identifying the boundary between counter-transference and the therapist's own complexes, but pointed out that it is essential for the recipient to be open to allow the 'mating' of the patients' projections with some part of their own internal objects, with some loss of boundaries between them. Bott Spillius (1988) reports that, according to Joseph, previously counter-transference was seen as an obstacle but now there is wider acceptance that:

'the way in which our patients communicate their problems to us is frequently beyond their individual associations and beyond their words, and can often only be gauged by means of the counter-transference.' (p72).

According to Money-Kyrle (1988), there are three factors – the emotional disturbance of the recipient, the patient's projections and their effects on the recipient – which need to be sorted in seconds for the recipient to effectively function as a receiving apparatus for counter-transference and to be a valuable tool in the therapeutic process. It is also vital in identifying and understanding these issues while consulting to agencies. The attention to counter-transference is what distinguishes the Tavistock method of (infant) observation used in this study.

It is not unusual for staff in the helping professions to be exposed to these experiences; the danger is if they remain unconscious, they may lead to being acted out and responding to clients in the counter-transference mode. In large teams with complex case loads, staff need the ability to process the distress of the clients and manage the projections and counter-transferences. These feelings have to be acknowledged and their meaning interpreted, leading to a discovery of what communication they represent. Within this study, the analysis of the data from each team includes a detailed comment of the researcher's counter-transference to these teams in an attempt to better understand the processes in them.

Reparation

Depressive anxiety follows whole object recognition in infants - the realisation that the good and loved mother is the same as the bad and rejecting mother. The anxiety is due

to the realisation that his aggressive impulses cause suffering and destruction to all the objects in his phantasy. His inability to repair this damage leads to intense guilt and the need for reparation. Hirschorn (1985) suggests that reparation is the cardinal motive in the work environment and can be achieved in various ways – through objects successfully made, services rendered, or healing the splits in interpersonal relationships. According to him:

‘ . . . when work is libidinised, it both produces and is nourished by reparation. Each time we take a role, we must aggress against our co-workers. But if we successfully take the role, then we also come to appreciate our co-workers. Seeing them whole we want to forgive and be forgiven. Only in such a climate do people feel free to take risks, to try something new, difficult and uncertain.’
(p351).

Several other writers such as Stokes and Segal have traced the origins of creativity to the need for reparation. Armstrong, Halton, Roberts, Hinshelwood and others have pointed out that reparation is the primary task of health and social care organisations. People working in them are relentlessly engaged in energetic reparation leading to burn-out, especially if they cannot exercise discretion and if there is little space for reflection or opportunity to gain insight into and address their need to do this work. Foster (1998b) suggests that:

‘ . . . a team that can locate within it a space in which disturbance can be owned, tolerated and confronted, and where a range of management and therapeutic skills are valued, becomes a team that is able to think reflectively and care appropriately.’ (p69)

Containment

At the non-verbal stage, a normal infantile relationship with the mother comprises of projecting those impulses into her that are the unbearable parts of the self and the anxieties that are too difficult for the infant to bear. The mother in turn receives and instinctively responds by containing the infant’s anxiety and alleviating it by her response

to him. Bion introduced the concepts of container-contained and applied them to situations of clinical treatment in mental health. He recognised that patients often split off parts of their 'self' and project them into staff in an attempt to evacuate the disturbing mental content but at the same time they may experience any intervention as critical and frightening as if the unbearable and meaningless mental content is pushed back into them thus leading to their disintegration. Staff need to be enabled to tolerate these projections and recognise them as forms of communication from the patients which need adequate acknowledgement and response. Thus facilitating the patient to experience 'containment' and enabling him to learn to tolerate his own impulses and begin to think about the experiences which were previously meaningless and frightening to him – which may further allow him to develop some level of engagement with the team.

Transferring this concept to organisations, Cooper and Dartington (2004) say that:

'... faced with the inchoate and primitive terrors of infantile emotional life, the mother is either herself sufficiently emotionally available to experience something of these terrors, and, drawing on her adult capacity for thoughtful endurance and suffering, to facilitate their transformation into states more tolerable for the infant – or she is not. Likewise, organisational processes are subject to distortion, disruption, and dysfunction in response to the anxieties and conflicts evoked by the primary task. In turn, the organisation may succeed in providing forms of relationship and thoughtfulness for employees exposed to these anxieties, thus enabling the work to proceed effectively and efficiently – or it may not' (p143).

Social Systems defences against anxiety

Using the psychoanalytical model, the findings of this study have been analysed focusing on *'the anxieties of care and the defensive techniques of the social defence system'* (Hinshelwood 2002a, p162). Writing in 1953, Jaques (1990), pointed out that people get together to form institutions to fulfil their needs, and although institutions take a life-form of their own, their culture and implicit functions are determined by the individuals who occupy particular roles within its social structure. He proposed the term social systems defence to describe processes set up to cope with work related anxieties in institutions.

In her study of nurses in a general hospital, Menzies Lyth (1988) demonstrated that members of organisations develop socially structured defence mechanisms which appear as the organisation's structure and mode of functioning. Over time, as they unconsciously collude with each other to avoid the anxieties generated by their work, these practices develop into aspects of the organisation's culture. The risk is that acute anxiety may cause groups of individuals to abandon mature methods of dealing with it and regress to more primitive methods of defence which avoid the primitive anxiety rather than aiding effective handling and working through it. Mosse (1994) reminds us that these are unconscious and therefore rigid and are resistant to change even if experienced as uncomfortable, because they have been collectively put in place to keep anxiety at bay. Menzies points out:

'Defences are and can be operated only by individuals. Their behaviour is the link between their psychic defences and the institution. Membership necessitates an adequate degree of matching between individual and social defence systems' (ibid, p73).

The personal valency (Bion 1961) and other complexes of the members affects their membership of organisations in relation to its social defence structures.

Primary Task

The concept of the Primary Task (PT) was introduced by Miller and Rice (1967, 1990), who were influenced by contemporary works of von Bertalanffy (1968), and Lewin (1948) in applying the open systems theory to human systems and likening an organisation to a living, growing organism with an import – conversion – export function enclosed within a finite, if permeable, boundary. They held two views of organisations, that they exist to ensure efficient task performance; and that it exists to satisfy the needs of those who are employed in it. Focusing on the primary task, they described it as *'the ordering of multiple activities of an organisation'* saying that though it is a heuristic concept it is necessary for the existence of the organisation. This concept has been further examined, redefined and expanded by a number of modern thinkers to include people systems such as healthcare organisations which operate upon persons and not material things or

technology. Lawrence (1985) proposed that organisations operated three primary tasks: the *normative primary task* is the formal or official task which operationalises the broad aims of the organisation and is defined by its chief stakeholders. The *existential primary task* is the task people within the enterprise believe they are carrying out; it is dependent on the meaning and interpretation that they attribute to their roles and activities. The *phenomenal primary task* is that task which can be inferred from observing the people's behaviour, and of which they may or may not be consciously aware.

Highlighting the limitations of the concept of PT, Armstrong (2002) points out:

'(PT) is fundamentally an instrumental notion tied to a concept of external goals or objectives, either explicit or implicitly. Its focus is on the end result, actual or anticipated. What is not captured is the journeying; or rather the journeying is simply read back from the end result, as if, for example, the object of a game were only to win' (p 92).

Shapiro (1985) observed that PT is a tool for examining an institution's changing activities in response to external environment and internal pressures and is central to understanding the unconscious processes. Menzies Lyth (1988) indicated that if the task definition is too difficult or when societal pressures are too great for adequate performance then the *'task may implicitly slip into anti-task.'* (p 224). Roberts (1994) has illustrated the anti-task phenomenon in her work. A further complexity brought to play in considering the primary task of multidisciplinary teams is the fact that these are task teams consisting of members who also have allegiance to their own professional or 'sentient groups' which Miller and Rice (1967) describe as that *'which members are prepared to commit themselves and on which they depend for emotional support.* (p253)

Boundaries

Miller and Rice (1967) specified that in the performance of the primary task for the very survival of the organisation, it must regulate its activities within a well-defined if permeable boundary with measurable intake-output ratio that can serve as a criterion of the performance. They stipulated that the basis for a general organisational theory

requires the precise definition and control of the boundaries of activity systems and of groups. In its 'purest' form, boundary control permits only those transactions between the system and its environment that are essential for performance of the primary task. It admits the necessary intakes, releases the outputs, and maintains and replenishes the resources of the task system.

Turquet (1985) pointed out that the open systems groups are involved not only in an internal/external world of differentiation but also in an internal world differentiation, in the setting up of the internal processes of intake, conversion, and output. Such internal processes help in turn to strengthen the boundary between the internal and external worlds and thereby to support the exercise of leadership function of boundary control. Shapiro (1985) elaborates that the task of management of internal boundaries in an organisation includes a monitoring of the relationship between the overall task of the enterprise and those of its internal structures, so that form is appropriate to function. Nonetheless, other factors in an organisation such as the personal needs of staff, covert tasks, their sentient loyalties and shared defences against anxiety may result in the formation of structures, internal to the organisation, which do not facilitate task performance.

Leadership

Based at the boundary and guarding it, is the leader. Hinshelwood and Skogstad (2000), state that the leader's role is *'to keep the organisation to the task, and to ensure that boundaries are effectively kept – which are central to the maintenance of the system.'* (p 166) In real terms, this is the role attributed to 'management' which implies organisational and personal leadership. Management needs architectonic qualities in that it discharges a three-fold responsibility – to the enterprise, to society and to the individual. Turquet (1985) points out that a further complication for leadership is that, like the psychoanalytic model of the ego, it is Janus-like, looking both internally and externally and becoming both participant and observer. If the leader allows himself to become an observer gliding above the fray as a non-participant, he will deprive himself of the knowledge of certain vital aspects of the group's activities. Hence he will lose much of

his evidence about the state of the group and especially the group's expectations with regard to his leadership. And indeed, there will be times when the only evidence available to him as to the state of the group's health will be as a participant, through his own personal experience of the group, what he feels the group is doing to him and how he 'feels' the group inside of himself.

Menzies observed that the real task of humane institutions can in a sense be described as relating to the dependency needs of staff but the primary task cannot be accomplished effectively by only gratifying these rather than by struggling for maturity, towards independence and realistic functioning. Aspects of good management include clarification of roles, clear task definition, clarity of responsibility and relationships involved, being given fully challenging tasks and the authority to carry them out, managing the relationships across boundaries and reconciling both the needs of the task and the psychosocial needs of the people - staff and clients. The introjections of the team's projections and general internalising of the way the group works, sets up a model of how individual staff will work with their own clients. It follows too that leadership has to act as a projection receptacle and to bear being used as such. Equally, of course, total immersion or loss of self in the group is destructive to leadership in the boundary function.

Successful leadership of a group involves participating in the basic assumption group that is appropriate to the aims of the work group and to the extent that the work is supported. Looked on differently, it may be said that the more successful leader detects and counteracts the emergence of any basic assumption group life that is inimical to the work group by virtue of its kind or its degree. The leader detects the basic assumption that is operative partly from the way the other members of the group are behaving and partly from his awareness of the manner in which he finds he is being made to participate.

Basic Assumptions

Other factors that may influence the commitment of an organisation to its primary task are the unconscious forces that affect the behaviour of the team when staff work in a group.

Through his extensive work with groups of people, Bion developed a framework to understand the irrational behaviours of groups. Stokes (1994) succinctly summarises this framework:

'Bion distinguished two main tendencies in the life of a group: the tendency towards work on the primary task or work group mentality, and a second, often unconscious, tendency to avoid work on the primary task, which he termed basic assumption mentality. These opposing tendencies can be thought of as the wish to face and work with reality, and the wish to evade it when it is painful or causes psychological conflict within or between group members.' (p20).

The work group tends to focus on the primary task and is intent on achieving it, however, when a basic assumption mentality is prevalent within the group, then the behaviour of the group is intent on addressing the unconscious needs of its members and reducing anxieties and other internal conflicts. This latter group behaves as if all the members share a basic assumption which could impact, colour, and permeate any rational work such as the performance of the primary task. Bion distinguished three basic assumptions, based on unconscious needs, each giving rise to particular behaviour in its members. A group dominated by basic assumption dependency (baD) behaves as if the group existed to support the dependency needs of its members. The leader is expected to look-after and sustain the members, fostering a pathological dependency and inhibiting development and growth. In basic assumption flight-fight, (baF), the struggle is against an enemy who should be either attacked or fled from – the group will do either as long as the leader recognises the enemy and devises the appropriate plan of action. In basic assumption pairing, (baP), there is an unconscious belief that whatever the present difficulties are, a future event will solve them, the group is not interested in achieving the solution but is sustained on a vague hope that something in the future will make its life better. Basic assumption groups come into existence spontaneously and are

characterised by collusive interdependence instilling an oceanic feeling of oneness and a lack of interest in interacting with the environment so that external reality is perceived as a threat to their existence. The roles of individual members are simple but rigid with no scope for individual skill or consideration for collective task implementation, so that a pure basic assumption group can continue to exist without focus on any 'work'. In contrast, it is rare to have a pure work group that does not tend to lapse into basic assumption elements. Turquet (1965) points out that one of the ways that a work group expresses its sophistication is through its use of a basic assumption element in furthering its work and achieving its primary task. The general theory is that it is part of the leader's task to mobilise the basic assumption mentality most directly related to the work that is on hand and use it in a sophisticated way in the constructive pursuit of the primary task, and by so mobilising, to eliminate the basic assumption most inimical and least amicable to the work task on hand.

Basic assumptions are typical of any type of person – each individual has a particular preference or valency for a particular kind of basic assumption life which is fulfilled by virtue of belonging to particular groups that will satisfy that basic assumption. However Foster (1998c) points out that *'the dominant defence against the anxiety of working with disturbed clients in this (CMHT) setting is one of fight or flight' (p 137)*, so that instead of offering an integrated service, clients are offered a fragmented one by staff, both by isolating their professional skills and differences or by obliterating them in favour of generalised working - giving up *'professional expertise in favour of team cosiness' (ibid)*; and avoiding the challenge of integrating the varied skills into a comprehensive service.

Team-in-the-mind

In discussing the role of the individual in both the work group and the basic assumption group, Turquet (1975, 1985) introduced the term 'organisation-in-the-mind'. Hinshelwood (2002b) points out that *'It is clearly a founding idea used by Jaques (1953) when he considered the 'phantasy structure and function' of an institution; and it has emerged more latterly as the 'institution in the mind (Armstrong 1991, 2005), or the 'workplace within' (Hirschorn 1995) – (P 207)*. According to Stokes (1994),

'It refers to the idea of the institution that each individual member carries in his or her mind. Members from different parts of the same organisation may have different pictures and these may be in contradiction to one another. Although, often partly unconscious, these pictures nevertheless inform and influence the behaviour and feelings of the members. An organisation is coherent to the extent that there is also a collective organisation-in-the-mind shared by all the members.'

Armstrong (1991) stresses that within organisations, each individual's *'experience is an aspect of, or a function of, the emotional experience that is contained within the inner psychic space of the organisation and the interactions of its members – the space between.'*

Within this research, the term 'team-in-the-mind' is used to capture this collective picture of the team experienced by individual staff members.

In the post-industrial milieu, developments in automation and communications have enabled the effective standardisation of procedures. In addition to this, integration of staff is achieved through professional training and agreeing a selection of operating norms which minimises the need for direct and constant control of professional staff. In working with people, Morgan (2006) argues that professional bureaucracy *'allows greater autonomy to staff and is appropriate for dealing with relatively stable conditions where the tasks are relatively complicated'* (p 50). Mental health work in the community consists of tasks that *'require judgements and decisions which cannot be taken by working out the 'right answer'. There may be many unknowns and complex interaction between different factors that have to be balanced and weighed'* (James and Clark 2002, p399).

Increasingly staff have to go beyond their own professional boundaries in performing their tasks within integrated multidisciplinary teams. In weighing up the risks and making the required judgements as they go about their day to day work in isolation, staff are influenced by their experience of their team-in-the-mind. Hinshelwood (2002b) emphasises that *'Individuals in roles absorb from the culture certain unconscious sets of values and beliefs. Reciprocally, individuals also tend to push the culture towards sets of values and beliefs, which individually held provide some comfort, and defensiveness*

against their personal anxieties'. However, this unconscious picture of the team could have contradictory elements causing confusion and ambivalence in the performance of their roles by individuals. Unless it is acknowledged and contemplated upon, it may result in unreflective decision-making in both, the day to day work and the construction of policy within teams. On the other hand, recognising its importance and reflecting upon it could facilitate the delivery of a seamless service envisaged in policies such as the CPA (as described above).

The Questions

My awareness of recent and contemporary writings gave me an overview gleaned from impressionistic discourses that lacked compelling evidence or broad generalisations from standardised quantitative research about the effects of this work on staff rather than the staff's own views and experiences of 'what', 'how' or 'why' things occurred. Further systematic search of relevant literature of research, reviews and illustrations of the concepts, failed to address these questions. Though many more qualitative surveys focusing on staff roles and burnout in mental health teams in the community using positivist methods were found, there was a lack of in-depth discussion of the issues and the personal liabilities for the workers in this field. Despite the acknowledgement that the paradigm of treating and 'containing' severe mental illness in the community is entirely alien to the tried and tested means of doing the same within the enclosed walls of a hospital, obvious questions were left unanswered.

This study was conceived to find out how staff cope with the psychological impact of working with the severely mentally ill in the community. To find answers to questions such as: Are staff aware of these impacts? How do they cope with the relative lack of meaningful achievement in their day-to-day work? What qualities do they possess to enable them to continue working in this way? Does professional training have any bearing on these experiences? What actually happens in these teams? What structures and processes are there to help staff?

Chapter 2:

Focus, Design and Methodology

Focus

In this chapter I will consider the methodological issues arising in designing a method to meet the aims of this research. Having started with an informed guess about the difficulties inherent in working with mental illness in the community, a thorough search of literature had generated no answers to the ethnographic questions I had; there was no published material relating to staff's own view of their work. Thus, the need to go directly to staff and teams working with this group of clients, observe the team processes and elicit their conscious experiences, distil common themes and interpret these using perspectives both within my own repertoire and from literature, became the central premise of this research. It was felt important to continue to see these staff within the context of their work in these teams in the community without making any assumptions about the rest of their lives away from this work. Indeed, there were no assumptions made about what might possibly be found. Instead, an exploratory approach was adopted, in order to investigate staff experiences of and responses to encounters with their clients as they visited them routinely, in an attempt to elaborate on what qualities they possess or rely upon and what processes occur in these teams to enable staff to cope with this work.

Design

The nature of the study and the requirement of my course necessitated a relatively small sample so that a qualitative research design was preferred using a method that was 'inductive' or 'grounded' rather than 'experimental' (Balint 1993). I agreed with the view that:

'Participant observations of ethnographic or case-study methods can be the original sources of insights which are subsequently formulated as concepts and hypotheses, and tested in more empirically rigorous ways' (Rustin 1997, p56).

The aim was to understand what is going on by collecting data without introducing too much disturbance, to minimise preconceptions in analysing the data and to allow themes about what is going on to emerge from it.

The initial design consisted of visiting 4 teams and conducting no more than 4-5 observations and interviews of front line staff in each, with the view to obtaining between 16-20 visit observations and interviews in each. This would be supplemented with 6 observations of the clinical team meetings in each team. In order to gain maximum advantage of using a small sample, it was decided to choose teams that had concentrated experience of non-compliant, non-engaging clients. The natural choice of teams then seemed to be the assertive outreach teams, as discussed below. These criteria of numbers and types of participants and nature of teams changed as the research progressed. This is further discussed in the section on Survey and Selection of Teams and Theoretical Influences below with more details in Chapter 6

In my attempt to capture the intra-psychic and inter-subjective experiences of staff as they interact with this particular group of clients, I favoured a research design that facilitated the gathering of data in its natural settings and interpreting the phenomena according to the meanings that participants themselves gave to them. My stance as a researcher would be that of participant observer, adopting a position between that of 'complete observer' and 'complete participant' (Gold 1958, in Hammersley & Atkinson 1995, p104). It was felt that participant observation of the interaction of staff with their clients during visits, using the infant observation method initiated by Bick (1964) would facilitate access to the unconscious dynamics of these contacts. Using the method adopted by Hinshelwood (2000) for observing health care organisations, further observations of team/clinical meetings were included to throw light on the interpersonal dynamics within these teams. In addition to eliciting the ability of staff to engage in obtaining support and making use of the team structures available, it would also draw my

attention to the resources within these teams. This would be further supplemented by an open-ended interview which would further elicit the conscious perceptions of staff regarding their work within the team in the community and also perhaps some unconscious themes.

Choice of Methods: co-relativity of paradigms

In choosing the methods to conduct this research, it was inevitable to focus on those that facilitate insights from the respondents' perspective. As Silverman (1997) states, '*no method of social research is right or wrong*' (p240), it depends on what is being attempted. However, the major method of systematic social inquiry in our contemporary world is the interview. As an interactional method it is a window into the internal world of the respondent. It allows them to verbalise a valid social construction of the situation being studied, based on their general conscious experience albeit within the framework of the questions used, which may be related more to the interviewer's perspective than those of the respondent. On the other hand, favouring the observation method, Hammersley and Atkinson (1995) point out:

'Ethnography as the most basic form of social research, bears close resemblance to the routine ways in which people make sense of the world in everyday life'(p1).

Rather than testing a hypothesis, it involves participant observation by the researcher in the exploration of a particular social phenomenon, by collecting unstructured data that is analysed to gain explicit interpretation of the meanings and contexts of human actions, through detailed descriptions rather than statistical tables.

Although this was an enquiry investigating ethnographic processes rather than testing a hypothesis, a case study design was preferred, as Rustin (1989) points out:

'Case-study research is most likely to be fertile in producing descriptions of new phenomenon, in finding hitherto unrecognised links between their different aspects, and in generating new hypothesis' (p71)

It is acknowledged that the teams, like all human organisations, are complex systems with intricate relationships which may produce unpredictable and transitory processes that are impossible to validate. However, triangulation was sought through using different kinds of theoretical concepts and multiple sources of data in concurrence with Fonagy and Moran (1993) (quoted by Briggs 1995 p42). After analysing the data from each team, it was presented back to the team for their view. In addition, a cross-comparison of the themes from the three teams would enrich the findings and throw light upon helpful processes and perceived difficulties within these teams. This way of supplementing the knowledge gained through one method with another, increases the intensity of the findings. For instance, open-ended interviews could elicit an insight into the conscious awareness of staff into their experiences of their work, whereas observing them interacting with their patients could allow an insight into their unconscious behaviours; this could be further enriched by observing team meetings, which allow further insight into their conduct while taking part in the interpersonal dynamics of their teams.

Observations

The Tavistock observation method consists of visiting once a week at regular times to enable the witnessing of the same set of activities; to remain open-minded and to record what has been seen, heard and felt in everyday language in a literal and factual way, without attempting to analyse or apply theoretical concepts at the time, to promote learning, to observe and also become aware of the feelings evoked by the experience, without immediate recourse to action.

This method was pioneered by Bick in the 1940s as a way to understand and personally experience the primitive anxieties of the infant and the development of defences as its relationship with its mother unfolds. Initially it was used to train child psychotherapists to gain these insights and to learn to apply them in the consulting room with the client, but it has since been extended to numerous other contexts. With some modifications it was applied to industrial, commercial and government organisations by consultants who followed the Tavistock tradition. It was used as a way to understand the behaviour of

interacting groups and to surmise the underlying anxieties and defences through the emotional experience of the observer, sensitively separating the observer's reactions to his own internal processes from those of the external phenomenon. In the 1980s, Hinshelwood (2002a) adapted the infant observation method to get trainee doctors to observe health and social care settings, encouraging them to attend to both observer introspection and attention to the organisational dynamics, and went on to publish a few of these. Teasing this out, Miles (1999) stresses that '*observing institutions is one way of making a bid for more thoughtfulness about our own work*'. (p68). She points out that it facilitates the observer '*to take account of the way decisions can be skewed and the primary task lost, if unhealthy institution and group dynamics cannot contain anxiety*.' (p72). It also assists in understanding the dynamics within the institutions, including the importance of clear boundaries, tasks and structures for the individual workers.

The infant observation method, as Bick (2002) pointed out, had two problems that needed to be considered: one was the conceptualisation of the observer's role of being:

'sufficiently inside the family to experience the emotional impact but not committed to act out any roles thrust upon him, such as giving advice or registering approval or disapproval' (p38)

and becoming aware of the conscious and unconscious attitudes of the observer due to the intense emotional impact when struggling to attain detachment - '*a position that will introduce as little distortion as possible into what is going on*' (*ibid* p39). However, the concept of an independent reality has evoked intense epistemological debates in terms of the possibility of conceiving an external reality without considering the observer's part in creating it. In addition, awareness of and the subsequent use of the transference and counter-transference which occur during observation is an important element of participant observation. In contrast, the scientific detachment needed in the positivist and a behavioural methods is seen as barriers to the psychodynamic insights potentially made available through this observational method. Chiesa (2000) asserts:

'It is important to realise that what is under study is a system which includes both observed and observer. In particular, a great deal of attention ought to be paid to the multi-level influence that the observer has on the observed, and to the way in which what he is observing will affect the quality of his observations. In other words, two aspects have to be taken into account: firstly, the observer's possible distortion of his observations; secondly, the observer's subjective involvement as the essential component of the observation. Only a fine line separates the former from the latter; it is therefore important for the observer to be supervised and to have the opportunity of discussing his experience in order to be able to disentangle what results from which of the two aspects' (p67).

It is essential that the researcher is thoroughly trained in remembering and accurately transcribing what has been observed, to enable a consistent account of the unique phenomenon under study. These inherent difficulties prevent the standardising of the research data gathered using this method. Hinshelwood (2002a) goes on to point out other problems, such as the observer's non-theoretical prejudices, pre-existing theory and circular proofs, over-interpreting and, especially, ignoring the smallness of the observer's keyhole vision. However, Rustin (1989) still argues:

'Its strength is intensive, not extensive, and lies in its depth and not its quantitative breadth. Like psychoanalytic clinical research, this work belongs in the context of discovery more comfortably than in the context of validation.'
(p71)

Having had training in infant observation as part of my PDSW course, I had developed the stance of holding back from leaping to the rescue of a distressed client in order to help them feel, conceptualise and formulate their internal processes. It had also facilitated an awareness of my own emotional responses and counter-transferences to the phenomenon. Further, by recording the observation as soon after as possible, I gradually learnt to formulate the sequence of occurrences as I observed them and hold them in memory to be able to write them down afterwards.

This was further enhanced by the research seminar as questions were asked, clarifications sought and interpretations made. This is a seminar for students on the PDSW course, who are at the stage of actually carrying out research. It is held fortnightly and consists of presentation of research material as it is collected and is a useful reference point in the lonely process of data collection. Hartland-Rowe (2005) asserts that the seminar discussions help alert the observer to what is left unobserved or undescribed, as they may be the internal responses of the individual to the phenomenon being observed, emphasizing:

'It is therefore the student whose development is the focus in the seminar; the development of their capacity to notice, to reflect, and to describe the immense emotional liveliness of their work' (p94)

In the current research, although the observations occurred in the team offices, there were no alterations requested to the routine of the team meetings and the client visits, instead I elected to follow the teams' normal routines as they occurred in these situations and paid special attention to the subjective feelings evoked in me by the observation experience, rather than selecting specific activities and ensuring they complied with a particular experimental design and offered objective factual data in the positivist mode. Although much effort had gone into establishing credibility as a fellow professional, it was not assumed that my presence had no effect on the various proceedings. On several occasions during the observation of visits to clients, staff seemed wary as they nervously gave me excessive explanations of the circumstances. This was also evident in their selection of patients, as most staff stated that they were choosing those who were easy to access and interacted well, despite my request to observe them with hard-to-reach clients. On the other hand, I was not able to detect any direct evidence of influencing the team meeting processes: this could be because it was not unusual for outsiders to be routinely attending them.

Interviews

Interviews are the most widely used method of conducting social research. It is a form of conversation which encompasses a wide range of information exchange, from free flowing interaction, through semi-structured or guided conversations to highly structured qualitatively standardised surveys. The framework of questions, from the researcher's perspective, potentially controls the understanding of the socially constructed worlds being examined through the confines of this interactional process. The traditional image of interviews as a neutral conversation, despite a highly sophisticated technology that informs how to ask questions, in what order, what not to ask and the ways to avoid bias and remain non-directional, further sharpens the debate over the epistemological status of interview data elicited in the search-and-discovery mission. As Holstein and Gubrium (1997) state:

'In other words, understanding how the meaning-making process unfolds in the interview is as critical as apprehending what is substantively asked and conveyed. The hows of interviewing, of course, refer to the interactional, narrative procedures of knowledge production not merely to interview techniques. The whats pertain to the issues guiding the interview, the content of questions, and the substantive information communicated by the respondent' (p114).

As interactional events, interviews depend on the interviewers to draw on their cultural competence and knowledge of the use of language and their ability to identify and explore what is implied, so that questions or probes are crucial to connect interests and evoke reports from respondents that are focussed on describing particular aspects of their lives, motivations, feelings, relationships, values and evaluations.

Within qualitative research, knowledge is not absolute; it is constructed in relation to the situation. Attending to the words and the meanings being constructed by the respondent helps the researcher to talk very little, except to gently nudge the respondents in the direction required by the research, by picking up on both the lucid accounts and those which are merely hinted at. Baker (1997) points out that focussing on the language used

facilitates the analysis of the interior states of mind and the exterior descriptions of social settings. Denzin and Lincoln (1998) alert us to the fact that the respondent is more than the text of the response, which itself has been shaped by the prior cultural understanding of both the researcher and the respondent. Although the respondents' lives outside the interviews shape the construction of the responses, feminist researchers such as Oakley (1981) emphasizes that if the interviewer enhances the quality of participation to ensure that the interviewee gets some satisfaction from the interviews, then, the quality of information elicited is superior. Whilst taking note of this and other elements of the feminist research philosophy such as recognising and dealing with the cultural barriers to communication, developing some degree of intimacy through investing the interviewer's own personal identity and being available to answer interviewees' questions, it is accepted that the interviewer-interviewee hierarchy is minimised but not completely obliterated. However, the researcher's self-portrayal as either too deeply committed to or clearly outside of the context, influences the choice of cultural stories that are revealed and the way they are presented. The interpretation and understanding of the responses are in turn greatly influenced by the researcher's own beliefs and interests. Miller and Glassner (1997) point out:

'numerous levels of representation occur from the moment of 'primary experience' to the reading of the researcher's textual presentation of findings, including the level of attending to the experience, telling it to the researcher, transcribing and analysing, what is told, and the reading.' (p101).

In conducting this research, the prior knowledge I had of the context was advantageous in understanding the circumstances of the responses. However, I had to be constantly vigilant and seek elaborations of the responses, to understand the points being made from the point of view of the respondents rather than colour these stories according to my own assumptions. Despite this, it is acknowledged that the whole process of doing this research has been greatly influenced by my knowledge and experience of the field. In introducing myself and my research project to the teams, I had briefly revealed my background. However, there was little curiosity about this, both in terms of what

experience I had and what work I was currently involved in, as if this information, like the professional checks I had, was for the consideration of the ethics committee only. At the same time I was aware that the research participants and most of the team accepted me as if I was another colleague who was involved in this particular work.

I was also careful to ensure that all the respondents were somewhat familiar with me through my observations of a few team meetings before approaching individual staff for their participation. Many of the participants were individually observed during their visits to their clients prior to being interviewed. This level of familiarity with the respondents enabled me to facilitate the weaving of authentic accounts of their personal worlds along with the cultural stories about the teams in their responses. I found that respondents often answered the questions I had on my list of 'guiding questions' (see Appendix) before I could ask them, enabling me to tease out more details in a way that was experienced as elaborating on their own utterances rather than as being introduced topics of interest to me as the researcher.

Ethical considerations

Research ethics are about how to acquire and disseminate trustworthy information in ways that cause no harm to those being studied (Rubin & Rubin, 1995). Ethics is defined by Robinson and Reed (1998):

'as a branch of philosophy concerned with what is good or bad for research participants; and what the moral obligations of the researcher are. Ethical issues are taken into account within planned research programmes to ensure that the rights of research participants are safeguarded. This is usually carried out by specially appointed ethics committees who attempt to ensure that these conditions are being met.' (p32).

Ethical concerns can arise at any stage of the research process, in the form of deciding what constitutes informed consent, what level of confidentiality should be respected/preserved, how the final written format is presented, the use to which the

findings are put and what access arrangements are made for the information. Mauthner et al (2002) comment that ethical dilemmas in thinking and decision making are influenced by both deontological¹ and the consequentialist position². Ethical obligations to respondents require avoiding deception, asking permission to record, and being honest about the intended use of the research – it also includes ensuring that respondents are not hurt emotionally, physically, or financially because they agreed to participate. The intricacies of this can be quite complicated; for instance, at the beginning of each visit, patients were informed of the purpose of the researcher accompanying their care coordinators and it was emphasised that the focus was on how staff dealt with the interaction. At one point within the work with the last team, a patient teased her care coordinator about ensuring that the researcher got the right sense of what had gone on between them. Nonetheless, there was a question about how much of the researcher's explanation and the prior permission sought by staff was understood by patients and whether their understanding had encompassed the comprehension that they would inadvertently become part of the data.

Even at the stage of analysis and reporting, manipulation of the data to achieve a desired outcome is ruled out by the responsibility to present accurate findings.

The presentations to the teams consisted of the list of themes and thoughts about how inferences could be made using Systems-Psychodynamic concepts. These 90 minute sessions included some discussions about 'areas for further improvement' for that team. As the process of data collection started to develop, I was astonished by the knowledge of systemic concepts and psychodynamic terms presented by the participants in their discussions. This shaped my decision to present the emerging themes in largely similar terms that I had used to code the data rather than develop an entirely separate document. It is also pleasing to note that in eventually disseminating the basic findings to the potential audience who would possibly read and even benefit from them, I would not have to make modifications in any substantial way.

¹ Kantian philosophy term - stemming from the notion that certain absolute rules exist and must be upheld regardless of the consequences

² based on a philosophy of the greatest good to the greatest number with the focus on the consequences of an action

In seeking the approval of the NHS ethics committee, the researcher had to demonstrate that systems were in place to ensure the confidentiality of the data collected. However, participants' concerns go beyond the simplistic assurances of anonymity and confidentiality, into gaining an understanding of what happens to their words – whether they will have credit for their views and ideas and how this will be revealed, especially where the information revealed is sensitive and potentially controversial. Another condition of ethics committee approval was that the participants had to be expressly informed that any malpractice found would have to be reported to the appropriate authorities. It is essential to recognise the disconcertingly complex moral dilemmas of carrying out a fair analysis or promised actions. Gregory (2003) indicates that ‘

Morality itself might be an arena of concern that has its own truths – though even if it is, our tragedy might be that we rarely know if we have found the true answer to a moral quandary.’ (p36)

Other ethical requirements included getting the individual participants to sign a consent form which clearly informed them of the details of the research indicating that their participation is completely voluntary. They were also advised about my obligation to ensure that they are alright at the end of the research process. Respondents initially expressed a fear of being asked ‘hard’ questions, but when the interview concluded they often told me that the process had made them think about issues that were not routinely on their mind and that they enjoyed the experience of being able to reflect upon these and openly discuss them.

Survey and selection of teams

Mental health services in the community comprise many different kinds of teams. Of these, Assertive Outreach Teams (AOTs) were especially set up to reach out to those patients who disengage after discharge from hospital although they continue to suffer from severe and enduring mental illness. At the initial stage it was decided to focus this research on AOTs in order to capture the essence of staff experiences with reluctant, non-compliant, disengaging and rejecting patients, notwithstanding the fact that these

teams were based on a well researched philosophy and practice of care and were very well resourced. In order to test the significance of the study and the relevance of the proposed methodology, several attempts were made to set up pilots with three different teams. Amongst those that agreed to take part, it was surprising to find how willing the team managers were to requests to observe the teams. As details of this study were discussed, it became obvious that most of these teams experienced a lot of interest from students and professionals who observed their work. Following the confirmation of the dates and details of these initial visits to the teams, they failed to materialise due to a variety of reasons, including a lightning national social workers' strike, the departure of a manager, and the absence of managers for personal reasons (such as moving house and sudden dependency leave) leading to last minute cancellations.

After detailed discussions within the Tavistock research seminar of the possible unconscious motivations for these cancellations, it was decided that the agreements of placement arrangements should be finalised through an introductory face-to-face meeting with the manager and possibly the team. It was hoped that this personal contact would allay some of the possible fears of these teams as to who I may be and how I may interpret their behaviours in what seems a very difficult work setting. The fact that I have a similar professional background and understand the intricacy of dealing with challenging and complex situations may become evident at such a meeting, facilitating a better response to the request for participation in this research.

The research plan consisted of choosing teams which were run by both statutory and non-statutory providers, but the issue was how to select a representative sample from across teams which ranged from well to poor functioning. To address this, a questionnaire³ was prepared to elicit detailed information of how staff in these teams were facilitated to do their work. This included the availability of policies and procedures, details of staff make-up, length of service, staff turnover and sickness, serious incidents involving staff and/or patients, support structures in the form of supervision, consultation and meetings including a brief format and content of these processes. This was sent to

³ copy appended

the managers of all the AOTs in London with the view that the returned responses could be analysed to identify those with qualities that fall within a range from well-functioning effective teams to those that are struggling to sustain themselves and achieve their objectives. The aim was to possibly identify teams which fall at the two extreme ends and also those which fall in the middle of the range ensuring that there was representation from right across to take part in this study. This initial anonymous request did not elicit any response. Three weeks later, the questionnaire was resent and immediately followed by a round of phone calls to all the team managers. Of those that I did manage to make contact with, several expressed an interest in taking part, saying that the questionnaire could be completed during the study. I also became aware that there were far fewer AOTs than anticipated. The National Service Frameworks for Mental Health had endorsed the idea that each local area should have assertive outreach teams. Following this, there had been a flurry of activity aimed at developing these services either as part of the statutory mental health services or in collaboration with leading voluntary agencies in each locality. However, on contacting several London Trusts, it became evident that many of these statutory AOTs had been subsumed into CMHTs and those run by the non-statutory organisations had been altogether disbanded or had changed their focus entirely. Further concerted efforts of meeting with 8 managers and 6 teams resulted in plans for data collection in the distant future as they indicated that they were either too busy immediately with pre-arranged student placements or changes in (funding) management, managers, consultants or other staff. Therefore time constraints ruled out participation by many of these teams as they underwent prolonged changes or needed elaborate ethics committee approvals.

I was fortunate in gaining easy access to an established AOT as a starting point. Whilst gathering data from the front line staff within this team as per my design, discussion with the research supervisors and peers indicated that in order to get a fuller picture of the processes within the teams and gain an in-depth understanding of what happens within them, I would need to involve as many staff as possible and also interview the managers to clarify lines of accountability. This meant that by the time I had completed collecting data within two teams, I had 12 team meeting observations, 18 interviews and 17 visit

observations. However, preliminary analysis of the data indicated that most Assertive Outreach Teams have elaborate team structures to support staff and so do not present a true picture of what actually happens to mental health staff in the community. Taking this into consideration, an endeavour was made to gather data from a generic community mental health team (CMHT). Following attempts to make contact with all the CMHTs in London by sending letters to the managers, intensive and repeated efforts were concentrated on 20, of which 8 teams were visited to explain the research project without succeeding in gaining agreement from any of them to participate in the study. A chance repeat of this request to a team manager during a phone call to discuss an entirely different (work) issue, finally obtained an agreement to meet with the team who then willingly agreed for a start before the end of the same week. Due to the relatively large amount of data collected within the three teams as shown in the table below, it was decided to not go on to include a fourth team

The following table contains details of the total data collected for this study.

Table 2.1 Data collected in this Study

Team Name:	Visit Observations	Team Observations	Staff Interviews	Total staff In team	Presentation Feedbacks
Outreach Homeless Team	9	6	10	14	6
Assertive Outreach Team	9	7	8	12	4
Community Mental Health Team	10	6	11	16	5
Totals	28	19	29	42	15

However, the unexpected unresponsiveness of teams to complete the initial questionnaire meant that I had to abandon my plan for statistical representation and resort to an opportunistic approach to locating the participant teams, as I did not have the information to locate them in the continuum of their functioning from good to bad. In addition the self-selection of the teams, who finally participated in the study, precluded any significant element of purposeful selection. In addition the case-study approach

detracts from the representativeness of these teams and hence the generalisability of the research findings. This has to be borne in mind during the analysis of the data and in drawing conclusions from the findings.

Data Analysis

The data gathered from the observations were in the form of narrative accounts, written down from memory as soon as possible after each session. Alongside a description of the events of the visit, my feelings in response to the encounters were recorded and other convergent and discrepant processes were also noted. Interviews were recorded and transcribed verbatim, including minute details in order to preserve the intended and unintended nuances of the discourses. Attempts were made to analyse the data to fairly reflect the findings in their context, notwithstanding the fact that these were complex self-organising systems whose properties are *'not explicable or predictable by reference to models of linear causation'* (Rustin 2002, p260), so that the interpretations made had to transcend the *'unwelcome dichotomy between causal reductionism on the one hand, and a merely interpretive investigation of narratives on the other'* (ibid. p263). This required using Geertz's (1983) formulation of 'thick descriptions' to stress the inclusion of cultural or contextual meaning in their interpretations. A simple table was developed which allowed each paragraph of the data to be studied for themes and for these themes to be coded – an illustration of this table is presented in Table 3.1 in the section on Counter-transference in Chapter 3

The intricate nature of analysing text obtained through observation or discourse to reflect aspects of the social world presents epistemological complications. Keeping this in mind, an attempt is made to gain a psychoanalytical understanding of the anxieties and defences presented by the respondents, while focussing on the systemic concepts such as the primary task of the team and the roles and processes within it, through the use of grounded theory. Conclusions are drawn and insights gained from both data that is present and that which is absent. For instance, noting the high levels of performance of the three participating teams, I am led to wonder if this had been a factor in their agreeing

to take part in this research and whether one of the reasons for the refusal of other teams might reflect their lower levels of functioning and the anxiety about it being potentially discovered by the researcher.

Theoretical influences in data analysis

An inductive approach to analyzing the data was used, making use of ideas from Grounded Theory (Glaser and Strauss, 1967). The aim of using grounded theory was to understand the research situation in its fullest form and to discern common themes within the various sets of data. Close analysis of the data enabled categories to arise and from this it was possible to begin to generate concepts about staff experiences of working with mentally ill patients in the community. The aim, as Glaser (1992) in particular states, was to discover the theory implicit in the data. This was driven by the data in such a way that the final shape of the theory was likely to provide a good fit to the research phenomena. According to Burke (1999):

'The strength of grounded theory lies in the framework it offers, the step by step guidelines for scrutinising qualitative material, ways to bypass researcher hypotheses, and to build up theoretical concepts 'grounded' in the research material.' (p14)

Grounded theory begins with a research situation; it helps the researcher to understand what is happening within a situation and how the players within that situation manage their roles. This method is especially relevant for qualitative research methods such as observation, and interview. The process consists of noting down the key issues after each observation or interview, identifying categories or themes and their properties as they emerge in the data. Charmaz (2003) states:

'Grounded theory contains both positivistic and interpretive elements. Its emphasis on using systematic techniques to study an external world remains consistent with positivism. Its stress on how people construct actions, meanings, and intentions is in keeping with interpretive traditions' (p85).

She points out that studying the process reveals several layers of meaning, which leads to thick descriptions which in turn facilitates categorisation of the emerging themes.

By analysing the data as it is collected, emerging themes can be constantly compared with the core concepts arrived at from previous data, allowing for modification of the instruments used for data collection and sometimes a change in the basic design and the methodology of the research. For instance, the guiding questions of the semi-structured interviews continued to be adjusted, even as data was being collected in the first team, to enable the collection of information that more comprehensively informed the research aim. Even the methodology changed from the original plan as the need for modifications became evident.

The analysis of the initial data from the first team was presented to the Research Seminar Group, which deliberated upon the containment offered to staff within this team. The group was curious as to the supportive structures that enable staff to function in this team. Questions were asked about structures for containment, areas of responsibility, lines of management and reporting, and systems of audit and monitoring that were used in this team. Most of these questions seemed to query the management structures within this team, confirming Roberts (1998a) emphasis that:

'In organisations, the containing function which makes thinking possible normally comes from management of the system, from firm boundaries and from the support and supervision that managers provide.' (p207).

Consideration of these comments from the seminar group resulted in extending the focus of the research beyond individual characteristics of staff in working with psychosis. A decision was made to include team processes and expanding the research cohort from front-line staff to include team managers and also making contact with the senior managers and regulators to access regulatory information about these teams.

Further, the analysis of the data from the first team showed that information from staff who had completed both the observation and the interview was richer in quality, compared to the information from staff who had randomly participated in either the

interview or the observation. Even within the former group, interview data from those staff with whom interviews were carried out after the visit observation had the added value of allowing me to seek clarification of issues that had been observed during the visit. Two possible reasons for this could be that in getting two lots of data from the same person, I had the opportunity to develop better trust with them which resulted in eliciting better quality information, and collecting data using two different methods from the same participants also ensured better triangulation. Following this discovery, I made a decision to subsequently ask all participating staff to take part in both the observation and the interview and I ensured that the interviews were carried out after the visit observations. However, there were exceptions to this; for instance, in the AOT, one staff member's visit was observed but repeated arrangements for an interview did not materialise; and in the other two teams, the managers did not have a caseload so that observation of a visit was not possible.

As the study progressed, analysis of the data revealed the extensive support structures available for staff in the AOTs. In the research design, these teams had been identified as the principle focus of the study. However, due to the skew in the availability of these structures, which from my own knowledge were not present in other community teams, a decision was made to include a CMHT in the research in order to evaluate the impact of this difference. Despite the delay that this would cause, in terms of identifying and getting the agreement of a new type of team to participate in the study, it was decided that the possibility of gaining a better understanding of the impact on staff of containing mental illness in the community was important enough for it to take precedence over considerations, such as the extra time and effort needed.

Later advocates of grounded theory point out that researchers bring certain presuppositions, depending on their background and theoretical bent, which influence the analysis and interpretation of the data. This was a complete departure from the original assertions of starting with no theory in mind but to be guided completely by what emerged from the data. Coffey and Atkinson (1996) assert:

'Theoretical ideas can and should inform the coding of data, but it is easy to endorse the view that a careful examination of codes can help to generate theoretical ideas. It should certainly not be assumed that theory can be 'built' by the aggregation and ordering of codes or the retrieval of coded segments. One must always be prepared to engage in creative intellectual work, to speculate about the data in order to have ideas, to try out a number of different ideas, to link one's ideas with those of others, and so to move conceptually from one's own research setting to a more general, even abstract, level of analytical thought' (p142).

As this research was looking at emotional impact and personal attributes rather than the sociological phenomena it was deemed appropriate to view the data from the systems and psychoanalytical perspectives both because of my own learning and practice background. In her succinct argument about the agreeable partnership between grounded theory and psychoanalytical research, Anderson (2006), points out that '*It is inevitable, necessary and therefore acceptable for the researcher to have a theoretical mind set.*' (p 333) In interpreting the themes which emerged in the data analysis, I turned to concepts such as 'Primary Task', as well as leadership from the systems perspective and related them to basic assumptions group analysis, while using psychoanalytical concepts such as projections, projective identification, denial and splitting. Objective concurrence in drawing out the themes and subjecting them to interpretations was amply sought from my research guide and by discussing the material extensively in the research seminars. It was felt that the participating teams would be interested in the findings once the data had been analysed. Presenting these findings back to the teams would be interesting and it would be used to obtain the teams' views which could then be incorporated into my findings. Thus an additional strand was proposed to this study, whereby the themes that emerged out of the observations and interviews could be further refined with feedback from the teams. Following the identification of these concepts and comparing their occurrence in the three participating teams, appropriate literature was accessed as it became relevant to the interpretation and understanding of the themes and concepts. This also ensured that pre-existing literature did not have excessive prior

importance. It was found that several of the themes which emerged, concurred with the findings of other writers of the emotional dynamics of working in community mental health teams like Obholzer and Roberts (1994) and others mentioned throughout this thesis.

Strengths, Limitations and Applications

The central premise of this research was to get staff themselves to describe in their own words and demonstrate through their actions what it is like to do this work. It is unique in that it used an exploratory approach that had the potential to demonstrate both the conscious and unconscious processes. Though there were some questions about processes, there was no definite hypothesis to prove. This makes the findings especially significant as they were elicited using a non-directive approach focussed on drawing out those themes that were of utmost significance to the participants in understanding the processes.

A thorough search of literature has not brought to light reports of any other study which has systematically studied 'soft' data emerging through participants' own words rather than through responses to pre-structured, pre-categorised, standardised schedules. Menzies-Lyth (1988) pointed out that the primitive anxieties evoked by the work situation lead to the development of socially structured defence mechanisms which, in time are incorporated as part of the culture and mode of functioning. Using the participant observation method to elicit information about these cultural structures further strengthens the insights into the respondents' own priorities about their work.

This was qualitative research using ethnographic methods carried out within three teams in inner London. Although this is a very small sample of all the services in London, each of these teams had a slightly different focus with regard to their primary task, ensuring an insight into the different kinds of community mental health services available in the UK. The majority of staff in each team participated but time constraints meant that there was a small number of staff in each team who could not be included. My attempts to triangulate the findings of the 'effective' functioning of these teams by acquiring evidence from the funding agencies and regulatory reports, add an extra dimension to these findings. It

counters the fact that only one formal support structure in the form of clinical meetings was included and also that no other records of any sort, including staff supervision and appraisal files, were examined to substantiate the individual performance of the staff. However, by closely following discussion of patients within the clinical meetings, which included expression of concerns, formulation of plans for intervention and follow-up reports of the effects of those interventions, a reasonable indication of the relationship of the team with its clients was gained. For the size and focus of this study, the amount of insight gained into its caseload was phenomenal. With my substantial experience of this kind of work both on the front-line and of managing staff in similar teams, I have developed an instinct for gauging user satisfaction with the service. The way staff discussed their clients in the team meetings and the way they interacted with them during the visits indicated a high level of functioning in all the three teams. Contact with funding agencies, such as local authority and PCT commissioners and regulators such as the Health Care Commission was made to elicit information about both their personal views of the teams and also objective reports and audits they may have about them. Though senior managers and funding agencies expressed particularly high opinions about these teams, no objective reports were available to validate my conclusion that these teams were functioning at above average levels.

The observational method facilitated my understanding of the research situation from my own perspective, both in terms of interpreting the observed processes and also through the examination of my own counter-transference feelings: it could be criticised as narrow and limited. But triangulation was imminently sought in the form of detailed discussions of the data and the analyses with my research guide/supervisor, the seminar group, the teams themselves and, on at least two occasions, larger groups of critics when selected sections of this research were presented at conferences. It is felt that this way of understanding staff experiences is comprehensive and has drawn out issues for consideration of policy makers and others responsible for making decisions about staff support and training. This method can certainly be applied to study other services, such as child protection teams. More detailed recommendations for further use and applications are made in the last chapter.

Presentation/ Arrangement of Findings &

Interpretations

Chapters 3, 4 and 5 illustrate my findings from each of the teams. These chapters include a detailed description of the themes that emerged in each dataset followed by broad interpretations of their meanings for the staff. Chapter 6 explores further areas of the three teams using additional data not included in the previous chapters followed by a comparison of the findings presented in the previous team-data chapters. The final chapter 7 consists of conclusions drawn from the findings and recommendations for their application.

Chapter 3:

The Outreach Homeless Team

Introduction

The Outreach Homeless Team (OHT) was the first team to take part in this study. It is an assertive outreach community mental health team operating at a pre-primary care level for people who are homeless and who have SMI. It is one of the teams set up in 1991 with funding from the Homeless Mentally Ill Initiative. The aim as described in the team's published reports was to clear the streets of London of homeless mentally ill people – to resettle them and link them up with the local services. The Initiative recognised that large numbers of people in inner cities with mental health problems and poor housing conditions tend to lose their tenancies as they become unwell and revert to the streets, night shelters and direct access hostels. This team provides a flexible mental health service for people who are homeless and socially excluded and who tend to become lost to statutory services. It strives to gain equality of access to services for these clients. Having started as a Health Initiative, it is now jointly funded and staffed by the local health service and social services. Members of the multidisciplinary team work as generic mental health workers, concentrating on reaching out into the streets and homeless hostels to engage these clients and also to liaise with other agencies in the voluntary and statutory sectors to ensure that their clients receive the services that they need and are entitled to.

The majority of staff in this team are nurses employed by the NHS Trust and social workers from the social services departments of the two boroughs served by the Trust. Though staff function as one single team with a single manager and consultant, there are two deputy managers who each lead one half of the team that focus on one borough. However, this division seems arbitrary as staff from other disciplines, such as occupational therapy, work across the two teams. Apart from the discipline specific

tasks, such as administering medication and doing formal Mental Health Act assessments, all staff are focussed on reaching out to clients and engaging them and helping them gain some stability in their lives. The team works from 9 am to 5 pm during the working week. As generic workers, apart from assessing clients' mental and physical health, staff address any needy aspect of the client's life, whether it is housing, finance or attending to their personal hygiene and cleaning their personal space, tailoring their level of involvement to suit the needs of each individual client and working at their pace. This may involve contact with the client over a long period of time until the client engages with services and is established in long-term accommodation for more than six months, when they are handed over to local mainstream services. Whilst there is a stable flow of referrals into this team, recently there has been a dramatic increase in the numbers of those clients who have drug and alcohol problems in addition to being homeless and mentally ill. The team has had to develop the knowledge and skills required to work with this latest problem.

Approved social workers participate in the ASW rota of their respective boroughs but there is no duty system in place within the team itself. There is a weekly clinical meeting to look at new referrals, consider initial assessments and discuss ongoing concerns about current clients. All assessments are done jointly and, if appropriate, one of the assessors might undertake further work and even the care coordinating responsibility. However, joint work continues until staff are completely comfortable with working alone with a client. Requests for joint visits with colleagues can be made at any time afterwards, especially if a client is found to be relapsing. The team is also supported by a monthly session with a psychologist who helps them deliberate on the psychodynamic aspects of their clients and the work they do. Though there are two medical staff dedicated to the team, medication is only a secondary consideration following the primary focus on engagement and social inclusion. With client choice being of prime importance in their work, staff have their sights set on the longer term goal of gaining the confidence and trust of clients, rather than an instant improvement in the symptoms of their mental illness. Another area of importance in the work of this team is the remarkable attention to the physical health of the clients. Thus staff seem to have developed a very high tolerance for the deplorable

presentation and behaviour of their clients. Training is another strand of work that this team do, using both staff within the team and a small group of staff dedicated to organising and offering the training. Expertise developed through years of working in this way is disseminated through training offered to staff from other statutory and voluntary services.

Emerging Themes

There are three sources of data for this team; observations of 6 clinical meetings of the team, 8 observations of staff visits to patients and 10 interviews with staff. Another source of data was the comments of staff on being presented with the themes that emerged from the data. Along with other staff volunteers, the consultant took part in both the observations and the interviews but since the manager does not do frontline work, she was only interviewed.

As the first team to be studied, volunteers were sought independently for visit observations and interviews, so that some of the staff participated in one and not the other, whereas a few participated in both. Whilst analysing the data for the team, I found that correlating visit observations with interviews helped me to get a better understanding of the themes. This led me to decide that in the following (two) teams, staff would be asked to take part in both as describe in Chapter 2 above. Each source of data is described briefly and themes identified. In describing the themes, excerpts have been used, mostly from that source of data but sometimes from other sources e.g. in describing Team meetings, excerpts from interviews have been used.

Team Meetings

This team has weekly clinical meetings every Monday morning. This meeting is the only time that the team members split up to meet in groups that are aligned with the two boroughs. The meetings take place in parallel in two adjacent meeting rooms leading off the corridor to the main office. For the duration of the meeting, the administrator remains in the office to take messages – if a crisis occurs during this time; it is taken to the team

manager, who does not attend these meetings. The deputy managers or other seniors lead these meetings, with the consultant attending with one group while the staff-grade doctor attends the other alternately. The purpose of these clinical team meetings is to deliberate on all new assessments and consider in detail the difficulties faced by team members with their existing clients. All new referrals are assessed by two staff members over a period of time, in order to accommodate engagement with the patients who are invariably homeless and difficult to contact. Though both staff contribute to the presentations at the meeting, the staff member who has undertaken to continue working with the client usually takes the lead. The rest of the team contribute their views if they have prior knowledge of the client, if not they contribute to the analysis of the issues presented, making suggestions as to what course of action may be possible with the client under the circumstances.

Staff take turns to present issues with existing clients and sometimes may also invite co-workers from other services to contribute to the discussion and to make joint care plans. Sometimes a decision is made for an urgent joint visit with another colleague who may volunteer to get involved to support the care coordinator, or an approved social worker may get involved to arrange a formal Mental Health Act assessment with the view to admitting the client to hospital. Brief notes about all the clients discussed in these meetings are written in a register by one of the staff – more as a record for absent staff, such as the team manager, rather than as a detailed report for other purposes. The clinical meeting is the only time that the staff team is divided. Otherwise they sit together in an open-plan office and share everything from the team manager, the medical staff, the administrator, the business team meeting and all other systems.

Nature of Clients

This team works with clients who are extremely chaotic and live at the edge of society. New referrals are taken on even if there is no obvious evidence of mental illness or diagnosis, as long as they are homeless and have engagement issues. New assessments consist of interviewing the clients and gathering information from other

agencies which may have had contact, both recently and historically, with the client. On the rare occasions when a carer is identified, all attempts are made to elicit information from them. Whilst getting the clients to engage, making contact is the principal focus; finding ways of doing this – of getting and holding the client's attention preoccupies the whole team. The following is an excerpt from a meeting, describing a very brief presentation of difficulties with an existing client:

Lou, the CPN, presented Liam, a 34 yr old man of Irish origin, who was known for nearly six years since the time when he was sleeping under a bridge. He was extremely hostile to the Homeless outreach worker and unwilling to engage in any kind of treatment regime. But when his paranoia increased and he had also become incontinent, the outreach worker had managed to arrange an admission to hospital under Section 2 of the MHA. Liam had been involved with drugs since his teens and had then turned to drinking in the last 12 years. Everyday when he wakes up in the afternoon he takes 8-10 pints of strong lager. He also takes a cocktail of drugs such as cannabis, heroin and crack, depending on his financial situation. He has an extensive forensic history including possessing knives, machetes and other bladed articles. He had been sent to the young offenders' institution when he was convicted for an assault on a police officer. His biological father had been convicted for a series of offences including murder. He had a difficult childhood with a string of step-fathers who were abusive towards him and his younger brother. He had looked after his brother but was not in touch anymore

His physical health is deteriorating and he suffers from chronic stomach ache and diarrhoea. His psychiatric history is unclear and though he had been in prison several times, he was diagnosed with schizophrenia only when he was formally detained in hospital recently. He had had paranoid delusions in the past but at present, though there was severe self neglect and his speech was slurred and jumbled, there was no evidence of thought disorder. He was currently living in a wet hostel where there was alcohol and drug dealing and the constant presence of police. He wanted to move from there so he could be away from drug users. He wants to

give up crack and has some insight into his paranoia and expresses doubt on his hearing voices – unsure whether it is real or not. His attendance at a day centre and engagement with the motivational work of the staff is erratic so that it is hard to predict what triggers disengagement. One staff asked whether he admitted to his crimes and was told that he denied he carried knives even when prompted about the need to protect himself. Someone else asked if he had been sweaty and drugged up, one of the social workers asked whether he could be invited to ‘pop’ into the drug advice centre but Lou said that as far as she could see he did not seem to be under the influence of any substance but his finger tips were severely burnt indicating extensive smoking. She said that he was vague and not very forthcoming with information, insisting that he took cannabis for relaxation and alcohol had become a habit. A CPN wondered if he was using these substances as self-medication to deal with his symptoms. Lou said that there was pressure of speech and he was gesticulating furiously insisting that people were trying to intimidate him as he commented on the random interactions of the people on the street.

A nurse wondered if he dealt with the shame of his failure and dependency by externalising and blaming the world. Lou said that he blamed his mother for all his problems including his schizophrenia. Another staff asked Lou if he made her feel that she was neglecting and persecuting him. The other social worker wondered if the team had an institutional counter-transference of wanting to ‘mother’ him as he had always been allocated female workers. There was laughter and some light-hearted banter until a nurse asked what his long term goals were and Lou said that he wants to do a vocational course but for the last 6 months he had just wanted to move into the present hostel. However, the move had brought on a different set of issues and now he wants to move on from there; Lou felt that he may leave without warning. He seemed unable to settle and it was difficult to understand how to help him. The occupational therapist pointed out that he was perhaps experiencing withdrawal and hence was unable to concentrate on anything – perhaps engaging him in something would help. Lou said that he was too chaotic to take up any employment or do any work – even something like woodwork. Another nurse

suggested that perhaps it would be useful to breakdown his long term goals into shorter term achievements. Did he believe that he should not take his tablets when he is drinking or taking other drugs – what was the reason for stopping Risperidone? There was discussion of whether he needs to see a doctor for a focussed conversation about his health, medication and side effects - perhaps a medical review. The consultant asked Lou whether he had seen this patient recently and was told that he had not but that Lou would initiate the idea with the client over the next few contacts with him.

This meeting creates a space for discussions such as these, where the number of queries raised open up venues for exploration. Analysing the type of questions that were asked by particular staff, there was no evidence to suggest that these were confined to the narrow focus of their own discipline – all staff seemed to be equally dedicated to creating a comprehensive picture of the client in order to explore what help may be given and what routes are most likely to succeed in engaging with the client and starting to address the large number of issues in every aspect of the client's life.

Treatment Interventions

Peeling away the layers of the chaos and problems engulfing each client with a view to making contact with them is the main focus of this team. The presence of mental illness is seen as just one of a plethora of contributing factors in a client's life that needs to be seen in perspective. Medical input is one of the options that are offered to the clients once they begin to engage with the team. Going at the pace of the client, work with them is painstakingly slow, sometimes spanning many years. Liaising with staff from the relevant services and also using every option available to locate and make contact with clients, staff in this team seem to be occupied in finding new and creative ways to make contact with clients, as in the following excerpt-

Rosie (OT) had invited Lyn from the Outreach Team to talk about Sophia who was born in India and had held a job until 12 years ago but who now literally lives on an underground train line during the day – mostly nodding off or even sleeping, whereas

at night when the trains stop she goes on the local buses until the trains start again. Each time Rosie has to ask station staff to locate the train that Sofia is riding on that particular day and no matter how often Rosie saw her, Sofia refuses to acknowledge her.

She has had several placements but is evicted each time as she isolates and neglects herself. She does not wash or settle down in any place but when she does, she puts a saucer of milk in the corner of her room to ward off evil. She had been assessed at the local psychiatric hospital but was not found to be psychotic. She does not engage and there is no rapport, despite persistent efforts for many years and each time Rosie makes contact there is no recognition or response to any communication. At one point Rosie took pictures of a care home which had a vacancy and which would tolerate her not washing but she had refused to go saying that she was not well and showed Rosie a wound on her lower abdomen which was oozing blood and pus. Rosie had tried over a long period to persuade her to see a doctor or have it dressed. Another MHA assessment was arranged and again she was not found to be detainable. A further Section 136 was arranged, but Rosie was on holiday and although she had been liaising intensively with the crime prevention unit, the police were not able to arrest Sofia as she was not creating any disturbance.

The SW asked what the MH issues were – how she survived. Rosie said that she looks well-fed but she does not wash – perhaps she has a fear of water – she doesn't change her clothes but she buys new ones and piles them on top of the old dirty ones. Another SW said that perhaps there is something about childhood abuse as abused children have a fear of water and do not like to wash and like to put on lots of layers of clothes. Rosie wrung her hands and said that would take a long time to find out as Sofia has hearing impairment so that she reverts to writing on a pad to communicate when she is feeling stressed – otherwise she communicates without any problem – she likes Cuban music and can talk very clearly for hours about it if you show interest.- as if music makes her come alive.

Rosie said that the manager had suggested that she should set up another Section 136 and make sure that the staff from within the team do the assessment-- especially as the previous attempts had failed. The deputy manager said that she would be involved as she has just come back from her ASW training. Discussion regarding post-discharge plans should begin now even as the 136 is being considered. One of the nurses suggested that they should organise a briefing with the police and crime prevention unit and maybe a case conference with police and the consultant. The aim was to try to get her into a direct access hostel where there is no expectation for her to wash. Also to get her checked up for the chronic physical infection she seems to be suffering and perhaps invite the Joint Homelessness Team in the local area of the tube line to get involved as she was often in their area. There was discussion about how long it may take to actually find her again.

Dangers such as physical violence were seen as one of the issues that need to be addressed using the appropriate services; some of the staff had laid charges against clients who had assaulted them. The clients may or may not be re-allocated to another staff but staff members continued their work in this team as if dealing with violence was just a routine part of their work. Most of the contacts with clients were short, focussing on a particular issue but the underlying theme of each meeting was engagement and the well-being of the clients. There was a great emphasis on liaising with other services that might have contact with the client and using the rapport of those agencies to develop a relationship with the client. I became aware from overhearing informal staff discussions that even the initial joint assessments were focused on bringing different perspectives rather than as a protection against potential violence

Support for staff

Though all staff who were at work attended this meeting, its loose structure meant that unless staff had been allocated new assessments, bringing a client or issue for discussion was entirely voluntary, so that I noticed two staff did not routinely participate in them. However, amongst other staff, senior and more experienced members of the team

seemed to use it for support as much as the younger more junior staff who also used it to acquire skills such as tolerance and reflection that are necessary to do this work. For instance in one meeting, one of the newer staff (CPN) presented this case:

A 35 yr old white male has left the detox unit and gone back to his originating borough – drinks up to 30 units of alcohol a day, was brought up in care and had been convicted for theft and beating up his flatmate as he believes that his flatmate stole his ID and is abducting and abusing children. He believes that he was involved in war when he was in care and talks very realistically about his actions when he was taking part in the ‘WAR’ – believing that he might have killed people. He is extremely thought disordered, chaotic with highly pressurised speech – jumbled up phrases – talked about a hypnotherapist who took the marbles out of his head.

The meeting heard this presentation, taking note of the increasing distress of the staff member as she anxiously described steps she had taken to make contact with the client – a long discussion ensued about what might happen to him and what services might become involved and how. It was concluded that should he deteriorate further he would be picked up locally and that nothing further could be done until that happened. This seemed helpful to the presenter who became less anxious as she became resigned to wait. These meetings were used to discuss difficulties and stagnation in case work with very difficult clients and to express despair at clients who did not achieve acceptable standards of living - the team helped this staff member to put things in perspective by considering all the possibilities and either suggesting action not thought of by the staff, such as keeping in touch with the hostel staff to keep his placement open, or pointing out the achievements of the worker, both with that client and with the client's network to introduce and maintain some stability in his life.

Staff appreciated the external consultant's facilitation of their reflection about their clients and their work, but felt that this was not enough help for the emotional stress inherent in this work. It was not untypical for staff to express their guilt about going on holiday and sometimes use jokes to deal with patients' rejections and complaints.

The importance of this meeting as a support structure was summed up by one staff who said in his interview that:

Um, and I always use the team as a real sounding board because, you know, if I was working with quite similar clients in the sort of way in which people present and the problems that we face, so, you know, we use these clinical team meetings just to discuss what people think and- 'cos you can often miss things or, you know, you're seeing someone fairly regularly, you're not fresh anymore, particularly to that person and someone might see something from a quite different perspective that you haven't really thought of before, so that's always quite useful. So it's a combination of all those factors, um, that you then, sort of then, make your judgement as to how you're gonna proceed – you know, what the next step'll be really –and -- and keep going at it!"

Visit Observation

In fulfilling their aim of clearing the streets and ensuring that homeless mentally ill people are engaged with the local services, staff within this team regularly visit their clients. The purpose of these visits is wide-ranging, from monitoring their health and well-being to giving information about an issue to maintaining contact with a view to improving rapport and developing a relationship. Regular visits to clients are undertaken at places that are convenient to them unless they are admitted to hospitals. One set of data for this research comes from observing 8 staff during a visit to their clients. 5 of these visits occurred in staffed hostels, one in the hospital, one in the drug centre and another in an advice centre for asylum seekers. During these visits, despite my expressed request, I did not get the sense that the clients had been informed beforehand about my attendance, but at the time of the visit I was introduced as a researcher gathering data and clients were invited to decide whether they wanted me to stay on. During one visit to the ward, the detained patient who was still very angry at having lost a Tribunal appeal against his detention a few days before the visit, expressly asked me to leave and then refused to engage with the care coordinator. On another occasion, the team consultant

had agreed for me to sit in on one of his out patient sessions but on this occasion none of his patients attended – at the end of the afternoon we took a taxi to a hostel to visit a client who was not present but another new resident asked to see the consultant and was briefly seen. Another staff member had arranged visits to several clients to ensure I observed at least one and we saw two clients during that visit. Due to the extremely chaotic lives led by these clients – visits require a lot of organising from booking rooms to ensuring that the clients are available by liaising with the hostel staff and other carers.

Staff Role

As the clients began to engage, staff would use their visits to address the quality of their lives – for instance, one entire visit was focussed on subtly encouraging the client to allow the worker (CPN) to assist her to sort out her clothes and clean her room. During another visit the worker (SW) was attempting to get the client to examine her current (abusive) relationship, after having waited two hours for the client to turn up for the meeting. While maintaining the main focus of getting clients engaged with services, staff often juggled the delicate balance between maintaining client confidentiality and involving various sections of the community to ensure their safety. This balancing act on the part of the staff seems to surround many aspects of their work with these clients, such as not hesitating to use lawful means to confront their antisocial behaviours while being very sympathetic to their clients' predicament, or considering the problems and consequences of the use of medication and hospitalisation versus long term engagement with the team. This is illustrated in the following excerpt taken from a visit which was not successful as described above so that the staff was subsequently observed participating in the ward-round to discuss the patient's ongoing care:

At the ward round, Michael (CPN) said that he had been very clear that Leslie was not ready for discharge last week but now after discussing with the team consultant, he was clear that there may not be such an advantage to putting him on a Section 3, as this may not help his long term engagement with the team. Michael wondered if it was possible to continue keeping Leslie on the ward once his Section 2 expired, with

a plan to let him go and spend some nights at his hostel. Michael felt that if he could go back and start working with the staff there with regard to cleaning his room and making it his home, it would be helpful in his engagement in the long run. The staff nurse pointed out that Leslie had been extremely unhappy with the tribunal decision and that he may not cooperate to stay on the ward informally – the ward staff did not feel that Leslie was well enough to be allowed to leave the ward. Michael said that Leslie's current sulk was habitual and did not indicate illness and he also felt that it would not be in Leslie's best interests to keep him detained as it would antagonise him and result in complete disengagement with the team. Perhaps Michael could use the experience of his current admission to persuade Leslie to take his medication though there is very little chance of retrospective insight regarding the advantages of medication as it had not made a striking difference.

Having just had the experience of being rejected by the client, the staff then spent a long time distinguishing normal behaviour from symptoms of illness using his prior knowledge of the client. Michael concentrated on negotiating with the ward staff the most appropriate way to care for this patient and helping them to recognise the long term (ill) effects of hospitalisation. Challenging the traditional view of hospitalisation as offering the ultimate health care, this team's general view of hospital wards is that they have limited value in responding to the real needs of the clients and do not particularly assist in identifying or actively addressing these needs. This view aids their emphasis on the least restrictive care with an eye on the longer term effects of any coercive treatments.

Staff Skills

In striving to engage with the clients, staff prioritise normalising their clients' experiences by including life issues rather than narrowly focussing only on illness ones. This requires staff to use all resources available to them to elicit information about clients' whereabouts and well being. During the visit with clients, a large part of the time was spent making contact with the staff of the residential units where the clients resided, whether it was a wet hostel, a night shelter, a direct access hostel or the hospital. It was observed that

staff in these units knew the visiting staff and often had good enough relations with them to engage in light hearted banter. This level of networking seems advantageous both as a support for staff in getting updates on clients and doing joint work with clients. It is helpful in ensuring that these clients are kept in the mind of those agencies so that their services are available on an ongoing basis to the clients. This level of joint working especially with the large numbers of voluntary agencies which are involved in supporting this group of clients has led to the establishment of the training unit within this team to enhance the limited training facilities available to voluntary agencies.

The most important skill that staff in this team require is that of persistence in the face of the elusiveness and sometimes outright rejecting behaviours of the clients. The fundamental expectation within the team is that staff would continue their attempts to make contact with clients despite numerous failures to do so. This often results in many months before clients are seen and sometimes many years before any level of engagement is achieved. Holding on to their anxieties and concerns for the clients over these long periods of time seems to be the norm. However, what is striking is the persistent creativity used by staff to encourage interaction during each visit, as in this excerpt from a visit with a care coordinator to a number of her clients at a wet hostel:

Helen (OT) reported to the staff at reception and was told that out of her three clients, one had gone to a gardening project at the day centre and the others may be in the cafeteria. We went into the cafeteria which had a large counter with a variety of foods from sandwiches and salads to several hot dishes. We saw Alice, one of Helen's clients sitting at a table with a big meal on her plate and surrounded by lots of packets of sandwiches, salads, desert etc. Alice did not seem particularly conscious of her surroundings. Helen asked whether we could join her, Alice smiled without looking up and continued to untidily shovel food into her mouth. She said 'No thanks', she did not need company today. Helen asked her if she remembered her and Alice shook her head still without looking up, so Helen introduced herself and me and asked again to sit down but was rebuffed again – so she said that she would be back as she was trying to find someone else.

We walked towards another table which had three staff and Helen started talking to them. She asked about the party they had organised the previous week. The staff produced a photo of Alice looking very dressed up and nice, whilst saying that since they had allowed drinks, lots of residents had joined in and Alice had even danced. Helen asked about another male client and was told that he had collected some food and gone back to his room and was in a nasty mood – Helen asked for his room number as she said that she felt alright to approach him as I was with her. Helen again stopped at Alice's table and asked her how the food was and Alice said 'It's alright', still avoiding to look at us. Helen asked her about the party saying that she seemed to have enjoyed herself thoroughly. Alice very slowly looked up at Helen with her mouth still very full, she said yes she had gone to the party as they would allow her to drink and she liked to dance anyway. She suddenly stood up and gathered all her packets of food. Helen asked her if she was going anywhere now. She said that she was going up to her room. As we followed her, Helen said that we were looking for room 50 and Alice responded that was on the same floor as her room as she pressed the lift button

In this excerpt Helen displays a studied familiarity with the client – always respecting her privacy by asking permission to join in when refused; she tries to introduce herself, fully acknowledging that she has not been recognised but using that as an opportunity to continue the conversation. She keeps her options to return to the client open by using the excuse of looking for someone else. She gathers some information about the client and returns to her, this time using the much enjoyed party as the topic of conversation and manages to make brief contact, but the client still will not stay – The ability to remain focussed on the client in the face of rejection and continue to think of creative ways to interest the client is an essential quality for working with this client group.

Counter-transference

In describing the client group, one of the staff said that some are difficult to make contact, some difficult to engage and others difficult to satisfy! Certainly during the visits I

observed, notwithstanding the chaos, there were some clients who kept up a relentless demand for money, for facilities, for medication, for independent accommodation and every other facility one could imagine. Nevertheless staff seemed to revel in the smallest achievement of each of their clients, whether it was that the client had taken on board a minor suggestion that staff had made such as joining a gardening group or a visit to the doctor. I was constantly struck by the persistence of staff and their focus on creative engagement with the client. Continuing with the above visit between Helen and Alice, we accompanied Alice as she reached her room, where the attempt to get Alice interacting continued as shown in the following excerpt (**Table 3.1**) which has both the observation notes and my comments:

Table 3-1 Observation Notes, Commentary & themes

Observation notes	My Comments	Themes
Alice did not invite us in, but Helen stood at the door of her room and commented on the Pimms jug standing on the table asking Alice if she had switched to drinking cocktails, Alice laughed and this somehow broke the ice and Helen entered the room.	Teasingly Helen continues her attempts to engage Alice	Staff skills of engagement
Helen asked if Alice remembers her, Alice shook her head so Helen reminded her who she was and asked Alice how she was. Alice said she was alright and did not want to talk today. Helen asked her what she was going to do now and Alice said she might go out for a bit. Alice kept looking at me so Helen introduced me again and Alice winked at me and said that everything was fine and bending forward she picked up an open beer can and took a sip of drink from it.	Helen again attempts to create a rapport by showing interest in the client's activities and then introduces herself and me	Patient characteristics
A moment's silence was broken by Helen asking what had happened to her young friend. Alice ignored her as she bent forward and picked up the two cans of beer one at a time and shook them to see if there was any beer left, she tried to put one to her mouth and missed it, lurching forward and spilling some of the beer on herself and Helen. Helen asked her where the third can was and Alice said that she had finished that too. Helen asked Alice if she had negotiated with the staff to have 2 cans in the morning and two in the afternoon – on repeating it, Alice retorted that she only had a ration of three cans a day.	Helen uses her knowledge of Alice and her friends to keep the conversation going. When she does not get a response, she comments on the beer	Staff role – persistence
Helen asked if she could sit down on the bed and Alice did not respond but looked at me and winked again. As she went towards the bed, Helen looked at the picture on the wall and commented on how lovely Alice looked, Alice agreed, winked at me as she bent forward and smoothed the cover on her bed, she told Helen, she could sit down.	Helen's persistence pays off – she is invited to sit and presumably continue the chat	Staff skills – creative engagement

<p>Helen again asked her if that picture was from the recent party, and Alice said that she had really enjoyed herself and danced but she did not like her room, she needed to go get a fag, Helen told her to go out and buy some fags as it was a lovely day, Alice said that she had not been too well – that she had gone and seen her doctor who had given her incontinence pads as she had a tiny problem with continence – she repeated this several times and standing up lifted her skirt to show off her continence pads Helen was very pleased and said so.</p>	<p>Helen acknowledges that Alice will drink and smoke but tries harm minimisation by asking her to pace her drinks and go for a walk before smoking – she also expresses pleasure at client having addressed her incontinence</p>	<p>Staff role – harm minimisation and patient’s physical health</p>
<p>Helen asked Alice if she would see a handsome young doctor when she repeated this, Alice winked at me and smiled and said she would see the man if he was handsome, Helen said that there was a lady doctor but she would get a handsome man to see Alice, who again reminded her that she had been prescribed the incontinence pads.</p>	<p>Helen entices client - teasing her while getting her to agree to see a doctor</p>	<p>Staff skill - engagement</p>
<p>There was silence where I felt that Alice was wanting us out and not wanting to continue the conversation. Helen said that she had been looking at getting Alice somewhere better to live but that she would have to face an interview and Alice immediately said that she did not mind it if she could go to her own flat .</p>	<p>Helen has to be creative and quickly think of something to attract client’s attention</p>	<p>Staff skill – persistence</p>
<p>Helen said that at this stage she perhaps could not go to her own flat but she could move somewhere a bit nicer so she had more room and staff to look after her. Alice got up and picked up the gold lame handbag which was lying on the floor and hung it on the wardrobe doors. Helen commented on the handbag saying that she herself would not mind one like that and Alice seemed pleased so she sat down again. Helen asked her if she remembered when she was seeing her doctor again, Alice clarified that it was not her doctor but the hospital who had told her to come back in two days’ time and had given her enough pads to last that long,</p>	<p>Helen is honest at the cost of losing client’s interest but uses admiration for patient’s belongings to flatter her and gain her attention and then gets the information Helen is after</p>	<p>Staff skill – persistence Nature of work</p>
<p>Alice stood up again muttering about cigarettes and Helen gave way and got up to go as we left the room Alice brought out a pack of cigarettes from her coat pocket and Helen said ‘so you have your ciggies’ and Alice did not respond, instead she asked if either of us had a light, Helen said that we did not smoke so she turned and just shut the door after her as she shuffled down the corridor towards the front stairs.</p>	<p>Helen has had her contact and managed to ask after client’s health and contact with hospital and is now ready to let go</p>	<p>Staff skill – respect for patient</p>

The ability of staff to keep in mind the positive aspects of their clients was evident from descriptions such as *‘he is a lovely guy’, ‘I really like her - she is so witty’*. This client group with difficult early experiences continue to be too damaged to form meaningful

relationships and require a level of persistent caring shown by Helen in her use of techniques ranging from uttering historical information to flattery and teasing. This results in some success in making contact with them. Helen's own way of dealing with the rejection of not being remembered by a client with whom she has been working for a long time, is to expect not to be recognised or acknowledged and take every opportunity to introduce herself - putting herself in context in the chaos of the client's life.

Staff interviews

4 out of the 10 staff interviewed were not observed during a visit, two were interviewed before they were observed, and although there was an opportunity to talk about issues during the visit, there was no systematic discussion of the observations as with the remaining 4. The manager was only interviewed as she did not do frontline work in this team. The merit of being able to elicit staff's views about elements of my observation of their visits in their interviews was evident during the analysis of the data for this team. It was decided to ensure that thereafter interviews were done after observations and attempts were made to interview all staff who had been observed visiting their clients. Participating staff come from different professional backgrounds, representing the skill mix within the team – with three each from nursing and social work, one OT, a deputy manager, the manager and consultant psychiatrist. Staff unanimously agreed that they worked as generic mental health workers, reaching out to those clients who were homeless and had mental health issues. Many of the clients used illicit substances and had a history of violence. All participants spontaneously said that they were fascinated with this group of clients because of their nature and presenting problems, but also because each day, work presents unexpected challenges. As one staff said:

I know this sounds idealistic but I wanted to go and do something meaningful --with people who don't have the kind of choices that – that I've had.

The meaning of 'assertive outreach' is interpreted as reaching out to people in their own space to make contact and re-engage them in meaningful relationships, whether they are accessible, as when they were admitted to the wards, or when they are in the community

and hard to find. All the interviewees unanimously expressed their view that this group of clients are very hard to work with, both because they are physically elusive and because of their state of mind. 8 out of the 10 staff interviewed talked about the intensive projections from their clients. 4 of those interviewed said that the psychologist who facilitated their support group focussed on the clients so that there was no genuine help to reflect on the emotional impact of the psychotic onslaughts of patients which had to be digested by being away from the team. All the staff had various personal interests and hobbies other than work and 4 out of the 10 only worked part time in the team.

Nature of the work

. . . . you know we kind of take a lot of cases where other teams say 'Oh we are not taking this on because there is no mental illness' but we say, no, you know that there is this going on and that going on and they are on the street and let's just go and take a look and I think we are quite open about that . . . so we sometimes get people nobody else wants to have time for, but I think we are able to just stay with it and see the good bits – you actually end up getting somewhere . . . Leon (SW)

Referrals to this team come from various statutory and voluntary agencies who encounter homeless people, from probation officers to night shelter staff. Some of these referrals may be of young people who are just developing an illness and have wandered away and become homeless because no one has picked it up, so they are not necessarily hard to engage, but have never really been identified as being ill. The team has flexible boundaries and rather loose entry criteria. From the very beginning, staff try to find a common ground and break down tasks into 'small manageable chunks' but the central issue is that they are not co-ordinating the care but delivering it. In trying to work with some of these very difficult clients, it is often easier to start with focussing on practical issues, such as housing and benefits. Having built up a level of relationship, staff are often faced with the difficult decision about getting the illness treated, which could mean having to force an admission to hospital under detention, whilst knowing that hospitals are inadequate to address the complex nature of the needs of these clients. But it is

harder when the wards are unable to recognise the nature of the client's illness and discharge them after a week, defeating the whole purpose of having taken away their liberty in the first place. Some of the clients have been so ill for so long that they have become permanently damaged and hospitals don't always seem to know quite what to make of them and what to do with them.

In trying to support people and empower them to improve their quality of life, staff liaise and do joint work with other agencies. However, in contrast to the inability to confront the 'Kafkaesque' procedures of the Home Office regarding refugees, with some agencies it is possible to advocate on the client's behalf and to challenge discrimination and even get legal representation to enable access to the facilities they need. Staff are also able to develop personal relationships with staff from other agencies, both through working with the same clients and also because this team offers training to staff from other statutory and voluntary agencies about homelessness and mental health.

Another appeal of working in this team is the relative lack of restriction on time-scales for engagement, permitting staff to concentrate on doing relationship based work. Team structures facilitate the development of coping strategies through self-reflection and thinking with supportive peers about their experiences, such as rejection from clients. Staff said this kind of learning enriched their own personal characteristics, such as their levels of tolerance and self-awareness. In describing this emotional learning from clients, a staff member (SW) referred to her experience with a client thus:

I had this client recently who's just left and she's quite personality disordered and she's a young woman and she's very chaotic and she would sit there and I would go along and I thought I'm going to kind of really offer as good a service as possible – she's had a really bad experience of services in the past. And she would sit there and I would say 'what are we going to talk about today?' – 'Dunno' – 'well, shall we explore this?' – 'maybe' – and it would just carry on for about ten minutes and just get to a point where I am starting to pull my hair out with her, 'perhaps we can talk about the impact of this on that – how do you feel about that? What strategies could you use?' – 'Dunno' - I just go arghhhhh! I can't bear it anymore but then you go

away and you try and think, why is she making me so angry, why do I feel so terrible when I'm with this person and just trying to kind of say what can I learn from this? Yeah, I really don't want this – so easy just to get up and go – ugh – it's a nightmare, I am just going to go away, I am not going to cut it but then 'that's exactly what this person wants you to do you know and I need to show her that I can tolerate that' and I went back and thought 'OK I am prepared for this – is this what you're going to do – I'm just going to let you do that because that's what you need to do , and that kind of learning and that kind of ability to erm, to-- to kind of respond like that, I just think it's an amazing thing to -- I don't mean I wasn't able to do it, I mean to make that learning and to have a job that allows you to learn about yourself like that – or when you kind of – you know I had clients who go off to – disappeared off and I get this fax through saying 'Hello – I'm in France doing this or whatever' – and I think 'Oh that's fantastic!!' – and you just think 'wow! – I've made a connection with that person and its--its kind of sustained over this time – how can that not make you want to come back and keep doing it you know yeah – so yeah----

There was unanimous agreement that on the whole, the team is engaged in trying to support its clients, to empower them to improve the quality of their lives and make a link despite their chaos.

Staff Qualities

All the staff have professional qualifications, some having joined following a student placement in the team, while others had learned about the team and actively sought employment in it. Staff said that the attractions of working in this team are the fascinating variety and range of client problems in addition to the flexibility of client choice and method of work within the team. When asked about what qualities the team manager would look for in staff, she said:

The first thing is, people need to be enthusiastic about the work, they need to be passionate about the work; they need to be very non-judgemental in their attitudes to homeless people – to be able to work with all sorts of weird and wonderful characters

and situations and be positive about it. People who can work as part of a team – people who will support each other and who are not particularly precious about their role – we have had a number of people who've come to the team- as locums perhaps and they say 'I'm a nurse and I do this' and they soon leave. For years the posts in the team were meant to have practitioner posts – pretty much generic – when we advertised posts - it was for MH practitioner and could be SW, OT or CPN, but most of the job description is still the same with a few different additions dependent on the person's professional background. So the ability to engage people who are hard to engage and having the skills to link with people brings all sorts of other things that help in working with people generally. It makes the team a nicer place to be because if your natural ability is to bring out the best in people then that would reflect how you work with your colleagues

Commenting further on the nature of the team's work in relation to the ethnic mix of the clients and the staff, the manager said:

The culture of homelessness was that traditionally services were provided by white Christian-based organisations, Salvation Army, Catholic Church, Quakers, etc. – and the client group was white older men - a lot of Scottish, Irish – drinkers. The client group has changed dramatically these past few years - and at least 25-30% of our clients are from BME communities and increasing.... But the staff group hasn't changed to reflect that – so we've had a problem in the team that's been a very white team – we have had a lot of Scottish, Irish workers in the team in the past, but the staff group hasn't changed to reflect the client group.

Motivation and an interest in doing this particular kind of work seems to be the most important quality needed to survive the intensity of demands in this team – to value the individual rather than be led by their diagnosis and feel enough concern to get 'involved' in their lives. The team has a number of professionals such as nurses, social workers, occupational therapists and medical staff but does not include enough specialist therapeutic skills needed to continue rehabilitative work with the clients following their engagement, whether it is psychological inputs such as CBT or help with more practical

day-to-day activities such as waking them up and helping them to get dressed, attend appointments – consider some kind of day occupation and get to them. As another senior member (Consultant) put it:

'We have a number of overlapping functions – the main one is engagement, outreach and engagement. But then you have the stage of intervention or treatment or whatever you want to call it, which can be pharmacological, psychological, social, and practical. Then beyond that we have the phase you might call rehabilitation. As many of our clients have been unwell for decades, rehab is in a sense what many of our clients' need – a long period of sustained work to help them improve their functioning. That's probably where the gap (in the team) is the most obvious'

The team works in close liaison with a number of voluntary organisations which run auxiliary services such as hostels, day centres, drug centres etc., however, a gap remains in targeting rehabilitation in terms of preparing for and maintaining activities of social inclusion and community living, in addition to the shortfall in ongoing psychological therapies for clients within the team.

Stressors and Supports

While discussing the stress experienced in this work, a majority of interviewees agreed that direct work with the clients was least strenuous despite it being hard. The myriad of client problems were attributed to the short comings in their environment in general. However, 3 out of the 10 staff interviewed identified that projections from clients were unbearable and emotionally draining but they did not hold the clients culpable for this instead reproaching the service for not having the right kinds of supports for staff.

I think the work with the clients is the nicest, most rewarding and easiest bit of it for the team generally.

Interviewees talked about the emotional impact of the horrific backgrounds of clients, especially when they start to talk about these while breaking down, and the helplessness of having to look on until they become ill enough to be forcibly detained in hospital,

especially as there was 100% consensus that ward admissions were not any good for their patients. All of them said that their greatest stress came from having to deal with the prejudice against their clients even from the relevant services;

Other teams in the Trust don't understand what we do ---I do find there's a lot of discrimination around from some of the other services as well and places like the homeless persons unit, who, as far as I am concerned, don't really care at all about the people they are housing, and the Home Office, dealing with the HO, um, sometimes dealing with the prisons and the courts and things like that, I find that, the hardest bit. .

However, there is acknowledgement of the risk inherent in reaching out to homeless people in the street or in their own spaces, and safeguards such as visiting in pairs and even joint allocations have been put in place.

We do need to be careful about boundaries and how we assess risk... sometimes people, in stretching the boundaries, accept a high level of risk. We need to be careful about that. The other thing we are struggling with and always have done is the paperwork, the bureaucracy, note keeping, electronic patient records. And the constant changes that we continuously have to adapt to.

Whilst talking about the stress caused by the difficulties of working in dilapidated office premises lacking in basic equipment and the lack of resources to provide for the clients' needs, one interviewee said,

you need to sort of step back, I s'pose is what I'm saying, and take a look at the big picture um, not to focus entirely on the brick wall, that appears to be in front of you, you know, to be able to step back and see over the wall or round the wall – so you've got something over the other side, sometimes you just feel that like you're pushing a rock up a hill and all you can see is – ha ha the rock against your nose kind of thing !!

In considering the bigger picture, all the interviewees unanimously agreed that in working with this team, they have to bend the rules a bit and think 'outside the box' and be very

creative as clients do not fit into the normal procedures, policies and bureaucracies. Staff worked very well together and supported each other;

. I wouldn't do another job – not in mental health - here there's camaraderie, there's a certain sense of humour, unconditional positive regard for each other, totally non-judgemental. We've all got funny quirks and eccentricities and that's accepted, and ----- appreciated and admired!! Any difficulties are sorted out. We've not had any difficult team dynamics for a long time. It's great we've got turnover – we've got new people coming in. We've got an excellent management.

There was unanimous appreciation of the supportive management within the team, offering both regular supervision and protection from the demands of senior management. Staff looked up to the team manager (and deputies) and the consultant for management support. Having risen through the ranks, these team members had extensive experience of front line work so that their advice was highly regarded by the whole team. The clinical team meeting and the monthly support from the external consultant were other structures mentioned in addition to the direct support from colleagues.

I think we have a lot of peer support in this team and I certainly feel it , you know d'ya know – the kind of warmth of colleagues – it is, it is a very kind team, you know – if you're having a difficult time people will be there for you – they'll let you talk, they'll kind of offer you help with things, erm – that helps a lot - like when you go out on a difficult visit and you come back and people are here and someone will make you a cup of tea and you know um its little things um but its important stuff

One important factor is that 4 out of the 10 interviewees are part-time staff. One other staff was considering reducing her hours whereas another staff member extolled his intense involvement with the training unit attached to this team in addition to his work in the team. In their spare time, the part-time staff pursued other activities that were totally unrelated to their preoccupation with homelessness or mental illness. The only interviewee who worked full time exclusively within the team was also the only one to

complain about the quantity of work and the lack of time to use the therapeutic skills he had acquired through studies over the years. Of the three senior staff interviewed, two also had other responsibilities outside their work in this team, while the other senior staff member had just returned from her ASW training and spent a substantial amount of her time in the team in organising user involvement.

Inferences and Organisational Themes

This research was set up to understand questions such as; how do teams in the community persist with constantly rejecting clients, what structures do they have in place to support their staff and what range of qualities do staff have to cope with these very disturbed and chaotic patients and their profuse projections and constant rejections? In seeking to answer these questions and also understand the unconscious factors that influence the behaviours of staff both individually and as a group, concepts deriving from both the psychoanalytical and systems perspectives have been applied to the data described in this chapter.

The Team as a Social System

In the hierarchy of mental health services, this Outreach Homeless team sits at the pre-primary level so that many of these patients do not have a GP and perhaps have never been identified as having a mental illness. Although the team is set up and funded by health and social services, it gets its referrals from those voluntary and charitable services which focus on the street homeless. They deal with people who have severed contacts with their communities as a way of coping with the frightening symptoms of mental illness or have become homeless due to their inability to sustain the level of functioning required to maintain their tenancies and have thus lost all contacts with the usual institutions of society.

Clients have no connections with primary care so it could be expected that one of the first tasks of engaging them is to get them attached to a GP service, especially as research has shown that a majority of them have physical health problems that need urgent and

ongoing attention. However their unstable and precarious existence in temporary shelters which they transiently access across the vast inner city areas rules out the possibility of being accepted by local primary health care services, until they are housed and have some stability. These structural difficulties in addition to their psychological complications in accessing services greatly increase the problem of working with these clients in any systematic way.

It is therefore essential that this team has access to enough skills in order to respond to the basic needs of their clients. The medical staff within this team address their mental health needs and they are encouraged to attend a local hospital for their physical health needs. In working with this chaos and confusion, it is essential that staff identify with the underdog, the underbelly of inner city life and use their knowledge and skills for creative ways of engaging with the clients and connecting them to the mainstream resources such as secondary mental health services.

The Primary Task

This team has staff from a range of different professional disciplines striving to achieve some uniformity in their approach to working with their very disordered clients. They have endeavoured to overcome the limits of both their individual professional training and the disparate ethos of their two very different employers in order to achieve a consistency in their approach and identity as mental health outreach workers with disengaged homeless clients. This team was set up with the primary objective of getting homeless people who also have a severe and enduring mental illness engaged with mainstream services. In understanding the team's primary task, further elaboration is sought using Gordon Lawrence's ideas that the primary task of an organisation consists of three aspects. The Normative Primary Task, or the task that this team was set up to do, is to engage with people with SMI and homelessness in their catchment area – the political agenda of public protection is to identify these clients and work with them in order to prevent them from posing a danger to society. The Existential Task, or the task that the staff themselves believe they are completely focussed on, is engaging with the clients to

improve their quality of life and address self damaging behaviours such as addictions. The Phenomenal Task, or the task that is evident in observing the functioning of this team, is to normalise those people who are on the fringe of society and to prevent self neglect and facilitate access to services. Staff think little of the dangers posed by these clients to society. Despite acknowledging that the damaging life experiences of these clients make them potentially dangerous both in their inability to form healthy attachments to services and, their involuntary projections on the staff themselves, staff firmly believe that these clients are victims of a ruthless society with its relentless demands so that they need and deserve unconditional help. This difference in view between the local political system and the staff who actually implement their expectations is not totally disparate, which is why this team remains effective both in terms of achieving its goals and surviving the constant political scrutiny of its cost effectiveness.

Basic assumptions

At its inception, this team brought together a number of senior staff who already had an interest in working with homeless mentally ill people. When money became available due to the pressures in political circles to address homelessness, it seemed natural to build on work that had already been done by them in similar projects previously. This level of experience and ability in senior staff could have resulted in nurturing dependency in new staff as they joined the team. The team culture of valuing independence in staff and encouraging them to test creative ways of using their skills enables them to expertly perform the day to day tasks towards achieving the team's objectives, so that though they respect both the consultant and the manager considerably, there is no dysfunctional dependency on them.

Staff felt that these two senior staff members could be fully relied upon to ensure the continuation of this team. They were aware of the drastic cuts occurring in the services around them and the funding crisis faced by both the statutory and voluntary services as they struggled to convince the bureaucracy of the importance of their existence. The grasp of the team's current political priorities by staff and some of the discussions in the

team meetings and individual interviews revealed that their expectation was based on real trust and not just a hope, that this pair would perform the miracles needed for their political survival.

In identifying with the clients and their struggles, staff ensured that they donned the gauntlet of challenge against the discrimination and lack of will within society to offer adequate services. Staff came alive as they empowered their clients to access legal supports to dispute these attitudes and prejudices. Whilst articulating their despair at such societal attitudes, staff expressed almost a delight at their ability to function in this way as if their life energy flowed from this fight mode. The checks applied by both their employers through constant demands for statistical and other justifications reminded staff of the allegiance to the larger systems, however remote, required for the continual funding for their existence. In addition, the external psychologist from within the Trust, who facilitated their support group, presented insights into their own behaviour and their relationships with their clients. This prevented the team from dwindling into a dysfunctional fight/flight mode.

The team was observed to have the capacity for the sophisticated use of all three of Bion's basic assumption behaviours while successfully keeping its focus on its primary task.

Social Defences

In analysing the data and understanding how this team deals with the primitive anxieties evoked by the incredible stories presented by the clients in terms of their early life experiences and the terrifying nature of their symptoms and examining how the team continues to function, it is imperative to understand the significance of the structures within it – and the most important one is that of engendering the sense of mutuality within the staff. All staff are professionally qualified and this is valued as having taught them the ability to have distinct boundaries between their own life situations and that of their clients. Other structures such as supervision and the more informal supports they offered each other were focussed on minimising the impact of their work

The use of the weekly clinical team meetings to facilitate additional staff involvement when well-known clients are in crisis or breaking down and becoming stressful to work with alone, nurtures a sense of 'being in it together'. This is made easier by the practice of joint assessment and often joint allocations of unknown clients or those that are known to have a history of violence. Close liaison with the voluntary sector agencies involved in work with this client group is one of the basic tenets of this team. There is a mutual dependency on these agencies to supply accommodation to the clients and provide ongoing information about their day to day situation while facilitating their work with these clients in terms of monitoring their well-being and facilitating their move on.

These practices in addition to the meetings with the external consultant are an attempt at reflective practice to facilitate productive responses to the primitive anxieties inherent in this work. However, the lack of robust psychological support for staff resulting in many of them being unable to remain in full-time work in this team reveals a lack of systematic understanding of the extent of the intolerable demands experienced by staff.

Projections, projective identification, denial and splitting

'I think it's that feeling of like all of somebody else's emotion has just landed on top of you and you try and hold them and sometimes UMMMM it's just too hard to hold it'.

This heart-felt quote from one of the interviewees substantiates the view that mentally ill patients are constantly projecting confusion and intolerable pain on to staff by their very behaviour, even before they have engaged with these staff.

In identifying with these projections, it is imperative that staff develop an intuition to know when to stop and ask for assistance from colleagues to share the brunt of these projections or seek time out for activities such as holidays which are purely pleasurable or pursue other mindless occupations such as digging up an allotment. However, in order to come back from these breaks and continue pursuing their clients, there needs to be an extent of identification with them and their experiences, of the feeling that *'it could have been me in their place'*. This capacity to identify with the client is essential to get on with

them and also to keep the arousal levels up in order to persist in their fight against the rigidity of the larger system. The other advantage of this identification with the clients is the experience of the feel-good factor in response to any small and almost insignificant achievements of clients – an essential ingredient in persevering in this work and tolerating the mountain of frustrations.

The view of the client as the underdog wronged by the system and their role in assisting 'David against the Goliath' of society reveals an unconscious denial of the magnitude of the damage caused by the experiences of mental illness in the clients, despite their knowledge and training. In donning an air of defiance against the lack of the same opportunities to their clients that are available to the staff themselves, there is also denial regarding the difference between themselves as independently functioning, productive units of society and their clients who are unproductive, dysfunctional and dependent on the goodwill of this very same society.

The team operates by splitting at various levels; at the level of the clients, staff see themselves as having the power to assist their helpless clients; at the level of the team, staff view it as a safe haven against the toxicities and dangers intrinsic in their work with these clients; at the level of their employers, staff are very defensive about their boundaries in the context of other teams in the mental health services, while being very flexible with the clients; and at the level of society, staff view it as withholding and ungenerous in contrast to themselves and a team which gives and gives. The team's survival ability seems to depend on clinging to feelings of being special by virtue of these distinctions. In comparing themselves with their deprived clients, staff are also critical of their working conditions within a building which was originally built as a workhouse to accommodate very similar clients, the lack of essential facilities such as telephones and computers as well as the lack of resources such as housing and day services for clients.

Humour was used as a way of alleviating the guilt felt by staff at the advantages and choices they had over their clients. Both in formal settings, such as the clinical meeting and within the informal exchanges between staff at their desks or at the coffee machine, jokes were constructed anecdotally around the rejections and complaints made by clients

and staff from other services. As a building block in the creation of solidarity with colleagues, it was used to acknowledge their mutual struggles with these clients. By easing the tensions evoked by the complaining and rejecting behaviours and turning them into jokes with colleagues, staff are able to continue offering stability and meaning to their relationship with their clients.

Conclusion

As a pioneering service for reaching out to those clients who have fallen through the safety net of mental health services, this team is remarkably effective in making contact with and engaging these clients. This has been achieved through its long experience in the field and the quality of the staff it manages to retain. By using the skills of qualified staff and its long associations with the voluntary organisations in this sector, it evidently succeeds in engaging with these clients and eventually bringing many of them into the folds of mainstream services. However, there is a relative disregard for the time scales involved in achieving this commitment, so that clients remain with the team for a long time before they are referred on. Though it is successful in the process of engagement, the team lacks the skills and resources for engaging in rehabilitative activities with these clients to stabilise them whilst preparing them both for social inclusion and independent living in society. As defence mechanisms, denial and projective identifications are functional when staff are enabled to persist with the rejecting clients; but become dysfunctional when these rejections are subsequently projected on to the 'establishment' and mainstream services, making them unable to work collaboratively with colleagues from mainstream services. The team has developed structures for the achievement of its primary objectives but these are not very effective in ensuring that staff feel supported so that the large number of staff working part-time may be a symptom of burnout.

Chapter 4:

The Assertive Outreach team

Introduction

The AOT is the second of the three inner city teams that took part in this study. With the liberalisation of views regarding the treatment of mental illness and the world-wide closure of long-term hospitals, it became necessary to establish ways of making and keeping contact with a small group of patients who consistently disengaged from services as soon as they were discharged into the community. The concept of assertively reaching out to these patients, in order to ensure that they are cared for and monitored, was first developed in the US by Stein and Test (1980) and popularised in Australia. The idea was piloted in the UK in the mid-90s and the Policy Implementation Guidelines for the National Service Frameworks for Mental Health (DH, 2000c), made it mandatory for mental health services to set up AOTs. This team has a high fidelity to the classic model, (SCMH 1998a, 2001); having small enough caseloads so that all the patients are known to all the staff, thus decreasing the burden on individual staff in dealing with the difficulties inherent in containing the chaos of these patients. The staff have ongoing specialised training, monitoring and operational policies, with clear procedures, including daily meetings and frequent recording of activities. Though staff work the usual full-time hours, they are expected to be flexible and cover much longer operational hours than CMHTs. Staff come from all relevant mental health disciplines, such as nursing, social work, psychology, occupational therapy, support work, and the team has a manager and dedicated clinicians. Individual staff have small caseloads of between 10 and 12 clients whom they are expected to care co-ordinate. However, all patients are cared for using a team approach, which means that, despite being responsible for their own clients, each staff member is also responsible for the care of all the clients in the team depending on their needs. Clients are seen as many times as necessary and at locations of their choice. Clients are referred to this team either because they are difficult to engage or

because they have multiple admissions to hospital, creating a revolving door phenomenon.

Many staff pursue professional development courses to ensure the availability of a wide range of skills within the team to address the needs of these patients. Activities undertaken by staff provide opportunities for use of their basic professional training and also the skills they have acquired in their areas of interest, e.g. one community psychiatric nurse specialised in working with dual-diagnosis, while another was training to be a systemic therapist. However, on the whole, all staff have a generic set of duties that they are expected to perform, such as medication monitoring, relapse prevention and various psychosocial interventions. The team is available between 9 am and 5 pm every day, including weekends, when there are two staff available. Each day there is an identified staff member on duty who coordinates the clinical team meeting and is also available to see patients who turn up at the office. Two other members of staff are designated to jointly dispense medication to patients who are either in crisis or unable to monitor their own medication. Students or other visitors to the team are paired up with each of the staff on medication rounds so that parallel visits may take place, thus freeing up permanent staff to undertake other activities. Assessments of newly referred clients are done in pairs, but if they pose a particular danger, such as sexual dis-inhibition, female staff do not visit them, even in pairs. Ongoing contact continues to be done in pairs until the care coordinator gets to know the client well enough to decide whether they are stable and can be visited alone. Care coordinators may do routine monitoring of their clients by visiting them alone in their homes or taking them out for a coffee or a meal. Support is also offered in attending meetings with other services and other practical tasks. In effect staff get involved in all aspects of the client's life to enable them to live in the community. If they are unable to support their clients with an activity, they write a note in the team diary with details of the activity, such as taking them shopping, helping them to put credit on their gas/electricity card, accompanying them to attend a benefits agency appointment, etc. or visiting for monitoring or giving them an injection. Each day these recorded requests from the diary are allocated to any available staff.

In addition to these day-to-day duties, staff hold specific responsibilities such as liaison with the pharmacy department to ensure that the medication cabinet is stocked, liaison with primary care to ensure an efficient relationship with the local GPs, audit of team activities such as CPA reviews and patient records, running a monthly activity for all patients of the team, etc. Response to a crisis is immediate and may include increased contacts or joint work with other teams. All patients are regularly reviewed at least once a week ensuring that some form of contact has taken place with each of them every week. A clinical meeting is held each working day of the week to discuss staff concerns about patients on their caseloads and to feedback information from activities of the previous day or two, especially with regard to those patients who are care coordinated by other staff. These meetings are also used to plan contacts and other activities for the day.

Emerging Themes

As with other teams the four sources of data for this team consisted of: 7 observations of the daily clinical team meetings done on a weekly basis, 9 observations of staff visits to clients and interviews with 8 staff. Information from the team-questionnaire was taken into account. One other source of data is the comments of staff on being presented with the themes that emerged from analysing the data from the team. As in other teams, volunteers were sought to take part in this study, however, in accordance with the conclusions drawn from the analyses of the data from the first team, it was decided to ask staff to participate in both the observation and the interview and to collect data in that order. One staff member took part in the observation but could not complete the interview despite concerted efforts, the social worker was 'too busy', the consultant went on maternity leave soon after I commenced data-collection in this team and the junior doctor had just started and was not able to take part. Each source of data is described briefly, identifying themes and illustrating them using excerpts from that dataset.

Team meetings

In this team, every morning all the staff attend a clinical meeting consisting of several parts, which lasts for between 45 minutes and an hour. The purpose of this team meeting is to create a space for discussing concerns, sharing routine information, briefly reviewing a group of patients and making plans, prioritising and allocating responsibilities for the day. For the purpose of this study, six morning meetings and one Friday evening meeting were observed. Though these clinical team meetings occurred every day, I observed them weekly but on the same day of the week. I came across the Friday meeting by accident following an interview with one of the staff. The nature of this meeting was different to those that occurred every morning, in that it was brief, less structured and with fewer staff present. There were no routine patient reviews but plans for the weekend staff were confirmed and a great emphasis was laid on recording all the meeting decisions in detail to make them available for the two staff on weekend duty.

The meeting room is rectangular and has the door and the stationery cabinets on one of the longer walls opposite which is a large board with the names of all the patients on the team's caseload in several columns like a giant open register. This also contains columns for the names of the care coordinator and any outstanding issues such as a CPA review, completion of a housing form, needing to visit the GP, etc. There are about 12 columns of 8-9 patients and the meeting goes through two columns each day so that there is continuous review and systematic scrutiny and planning of each patient's care. On the smaller wall is a large medicine cabinet and on the opposite wall is a smaller board with the names of those patients who are at immediate risk and who need daily visits. Names of patients are added to or deleted from this smaller board depending on changes in the patient's circumstances. All staff contribute to this sharing of information and care planning, ensuring that all of them share the responsibility both for planning and implementing the care plans.

Team Approach

The meeting starts with individual feedback from each staff about patients they have seen since attending the last meeting. Staff initiate discussions about patients they have recently seen and others may contribute to the discussions from their own contacts, impressions or previous experience of the patient and a plan of action is jointly decided along with an agreement as to who will carry out each aspect of this plan. Following this detailed patient feedback and planning of activity, visits to the patients on the medication board are planned. This is followed by eliciting updates on patients from two columns on the large open register. The staff member on duty who chairs this meeting examines the team diary which consists of special requests for support written down by other staff. Depending on their appointments for the day, staff mostly volunteer to undertake these activities. When there are no volunteers, all staff consult their diaries and announce their plans for the day and the manager decides which particular staff should prioritise these activities. In this way these diarised requests are given priority over some of the routine tasks carried out by individual staff. Though there is an identified care-coordinator for each client, all staff aim to have up-to-date knowledge of each client through the detailed discussions of their current situation in these meetings.

One staff member (CPN) said of the team approach:

'--- the team approach whereby you have a case load and you are the care coordinator for 10 people but you share responsibilities with the whole team - different professional workers – err nurses, doctors psychologists and even students -- and, though the patient maybe yours the decisions that you make will be joint decisions with the team even though you may see that person once or twice a week, other members of the team are seeing that person as well so you don't kind of get tunnelled into one view about what you think about what you saw and assessed, you've got somebody to share what you're thinking and feeling and you've always got somebody to share the decisions around care that you are trying to put in place for that person so it's a really good model – really good one – I'm really pleased with the

way it works because I find that in sharing the responsibilities when its time for me to go on annual leave that I don't have to worry about my patients because I know that others in the team know the patient just as well as me and once I've handed over the care I can rely on the team to sort of pick up where I left off so a holiday is really a holiday instead of thinking oh no – I've left this piece of work – I wonder if their medication will be given to them or whether they are going to make such and such a meeting – I know that there is somebody who is going to pick it up for me and vice versa and they can rest assured that another member of the team whether they are sick or whatever that somebody will pick up what they've left – there is always somebody else who knows the person you are working with so the pressure is kind of shared

In this team, care coordinators have nominal responsibility as different aspects of care are undertaken by different staff depending on their availability and skill. This way of working collectively with each client ensures ongoing support for them without interruption to their treatment and care in spite of staff absence through holidays, sickness or resignation. In a team that has been set up to care for those severely ill patients who have been given up by other teams due to their difficult and demanding behaviours, this way of holding team responsibility reduces the stress on staff of being solely responsible for these very challenging patients and also facilitates strong bonding between staff in the team. Describing the importance of this meeting, another staff (psychologist) said:

I suppose that a lot of the patients we have, have had experiences of care coordinators that have given up on them because it is so difficult and because it is sort of the team work - the process where we can talk about them and understand them with a bit of discussion and also because we all feel a bit supported by each other we are not as likely to burn out and give up on our patients you know someone might come and just go 'Arh, I'm tearing my hair out about Helen (patient) and someone else in the room will go 'well have you thought about this' – I think the team approach helps us not to give the patients the experience they possibly have had over and over and over in their life of people giving up on them

Most of the structures in this team have been carefully set up to encourage patients' bonding with the team rather than to individual staff – with a focus on forming attachments with the whole team rather than individual staff. However, for a team approach to work effectively, it requires a manager who has a strong overview of the team and team practices that encourage shared knowledge of each patient. The manager of this team is a keen advocate of the model and very dedicated to making the team work.

Treatment interventions

Medication is the most important aspect of the patients' treatment and care in this team. Referral to it is the result of disengagement with services or the inability to stay out of hospital – a major reason for this is non-compliance with medication either because of active resistance or an inability to take responsibility. As a consequence, a large part of the team's initial assessment consists of the patient's ability to comply with and also be responsible for their own medication. The care-plan that is developed consists of elaborate details of how medication is initially monitored with the aim of teaching patients to self-medicate. Medication is regularly reviewed by the doctors within the team who periodically accompany staff during their visits to clients. One of the smaller walls in the meeting room is dedicated to maintaining a list of patients who need their medication monitored in detail. Those patients who are found to be unable to self-medicate, either because they forget or abuse prescribed medication, are identified and regularly reviewed with regard to their compliance and their ability to correctly take medication. A major day-to-day responsibility for the staff is to undertake the task of doing joint visits to those patients who are relapsing in order to hand deliver their prescribed medicine to them and monitor their health and well-being and thus prevent hospital admission. In this way, patients who are at risk are seen daily or less frequently as decided by the team at the clinical meetings.

A majority of staff are nurses: this coupled with two doctors dedicated to a team which has a relatively small caseload compared to other teams, evidences the emphasis on

medical intervention for patients. Staff are made available everyday in the form of nurse on office duty for those clients who make unplanned visits or attend the office to take their depot medication. In an interview, a staff member described an incident when a patient had attended the office in an acute anxiety state prior to going on a long journey to visit his mother. While describing this event, staff emphasized the fact that whilst providing assurance to the patient, a major effort had been dedicated to getting him to take his medication even though this patient was normally self-medicating. This staff member had spent a long time supporting the patient's mother to facilitate the visit by talking to her on the phone. Apart from assuring her that the patient was only anxious about the journey and that he was not actually suffering any symptoms, staff emphasised that she should ensure that he took his medication in order to maintain his health and for the visit to go smoothly.

Though medical treatment is considered the most important form of intervention, staff in this team are encouraged to develop skills in psychosocial treatments. Apart from enhancing their professional skills by undertaking post-qualifying studies, 5 out of the 8 staff interviewed were pursuing further qualifications in psychosocial interventions such as family therapy, CBT, counselling and specialist interventions for clients with dual diagnosis. The clinical team meetings elicited discussions about several areas of help that clients needed support with. The open register of the team's caseload contained details of the practical help required by each patient. Discussions about which of the staff could undertake these interventions with patients on a day-to-day basis led to planning for these activities each day. These discussions often revealed the use of psychodynamic insights into patients' behaviours, systemic interventions involving family and other carers and CBT techniques with patients. The whole team had attended a course for an extended period, at the Tavistock Clinic, to gain psychodynamic insights into their patients' behaviours and to understand their own personal reactions and working patterns.

This is a team which supports extremely vulnerable people with complex needs. Many of them are damaged to the extent that they are not able to form meaningful attachments. It

is the practice in the team to prioritise practical tasks with clients as a technique for developing a relationship with them. The huge open register occupying the largest wall in the meeting room and the continuous care-plan reviews are evidence of this focus on keeping clients in the community. The team diary also contains everyday reminders to the team of the help that patients need regarding various aspects of their lives. In the meeting, staff are appointed to carry out these tasks irrespective of whether they care coordinate these clients. This way of prioritising practical issues as a way of keeping them engaged with the team, is particularly significant with this group of patients as their disengagement from services could lead to disastrous consequences to themselves and sometimes to society at large.

In the meeting, staff discussed risky behaviour of patients and it was evident that joint decision making encouraged staff to tolerate highly risky behaviours from patients, by pairing up and increasing the frequency of contacts and by doing ongoing risk assessments. Staff's anxieties about accepting the risks inherent in the very nature of their work were contained by the fact that the team had in place several structures, such as supportive individual supervision, a support group facilitated by an external consultant and regular liaison meetings with other services, in addition to using the team approach in their day-to-day work. Patients who were referred into the team or those that needed to be referred on to other services were carefully assessed with regard to the risks they faced or posed. The intensive liaison with staff in all the services that patients were involved with focussed on risk, while keeping in mind the help they needed to stay out of hospital.

Support for staff

All staff cited the team meeting as the single most significant supportive structure within the team, despite the fact that every fortnight there was a support meeting with an external consultant who helped them to examine the relationship between work and personal issues, continuing the training they initially had at the Tavistock. The supportive nature of the team meetings was clearly evident as staff brought their difficulties with

clients and even directly asked for help from other staff. They often held on to the hurtful experiences in their day-to-day work and shared it with the team in these meetings – depending on it to put their daily experiences into perspective. Examples of how staff asked for and got support in these meetings were available in each of the 7 observations:

Hilary (CPN) talked about another patient who has a lot of physical problems. She suggested she have a short respite at the local crisis centre but the patient has consistently refused. But now she had finally started to think about it, Hilary did not feel too sure herself about the suitability of the respite centre for this patient, so she asked for a bit of help with the assessment. She felt that she had been spending a lot of time with her and wanted another perspective – Tim offered to go and see the patient in order to assess whether she would make use of this move.

And in another meeting;

Gemma talked about a client who is being evicted and the Housing Association had asked staff to clear out the flat as there is a lot of rubbish – Gemma said that she needed time and support from another colleague to go and bag up all the rubbish as there was a lot of stuff. After some discussion Marcus agreed to help out with the clearing.

However, this subjective experience of the supportive nature of this meeting is in stark contrast to the response some staff got when they shared patient behaviour that was experienced as distressing. When staff occasionally revealed a painful exchange with a patient, the team's response was not to explore the feelings or empathise with the staff but to concentrate on arranging a review of the patient. The walls of the staff office were plastered with computer prints of photographs with and without captions of various team outings - perhaps as a reminder to all staff about where they could take their troublesome feelings.

Leslie (SW) fed back about a visit to a client who had been preoccupied with his feelings towards him – as a justification for his animosity towards Leslie, the client had said that Leslie had approached him for sex and that he does not like to have sex

with 'white boys'. The discussion that followed was about how long it would be before this client would have to have a formal assessment under the Mental Health Act

In 4 out of the 7 meetings observed, staff were found to engage in humorous interludes, using jokes and other descriptive metaphors to enhance the account of certain behaviours of patients.

Alan discussed a client who was heavily into non-prescribed drugs. When he was last visited, he claimed that he had been shot by his drug dealer. Alan had offered to examine him and had not been able to find any wound in his head. There was general laughter and jokes about whether he was shot at all and who by. The discussion continued with several staff saying that perhaps it may be true in a Pulp-Fiction sort of way – there was more laughter as they started discussing about something else. Alan looked sheepish but did not ask for any more support with this client.

A closer examination of the timing and content of these jovial transactions revealed that they were often used to mask the uncomfortable feelings, such as envy and fear, evoked by these behaviours. My own feelings during these meetings were mostly of being contained – of an environment which encouraged a business-like focus on the clients' needs. But on a few occasions I was conscious of feeling ill at ease with the response elicited by some issues and by particular staff – feeling distant and unconnected. On following this up with one of them in their interview, it was evident that they were more boundaried about their relationship with the team in comparison to the other research participants from this team; another attended few meetings and was not able to take part in the research as 'he was very busy'. Nevertheless, this meeting was declared to be the most important supportive structure that enabled staff to continue working with this client group.

Visit Observations

One of the tenets of the classical model of assertive outreach is to reach out to clients at a place and time that is convenient to the latter. In this team a range of interval between visits was offered to patients, varying from several contacts a day to weekly visits, depending on their vulnerability and need. A major part of staff preoccupation is to visit patients, whether as part of the daily medication rounds, or to help clients undertake practical day to day tasks, or to enhance their social/leisure activities, or as part of the ongoing review of their wellbeing. The staff said that they had informed the clients beforehand about my accompanying them during the visit; however, on at least two occasions clients being visited were not available, so alternatives in the form of ad hoc visits to other clients took place. A number of clients were also not available to accept their medication. This was immediately conveyed back to the office so that the duty nurse made arrangements for another staff to visit. A student also accompanied the care coordinator and me on one of the visits. This observation, consisting of visits to three clients, was done following the medicine rounds using the team car. Four out of the nine observations were of visits to more than one client. Six of them were in the homes of clients, two were on the acute wards of the hospital and one in a restaurant, another aborted visit was also to have taken place in a restaurant. I did not avail of the patients' notes in preparation of these visits, instead staff gave me a brief description of the patient's background on the way to the visit and on the way back. This information is included in the observation report of each of the visits.

Staff role

The most important difference in an assertive outreach team is the possibility of increasing the frequency of contact with patients. During observation visits it was evident that all the patients had had recent contacts with other staff in the team. No matter how ill they seemed, patients were able to recall the names of the staff they had had particular contact with and displayed an expectation that the staff on the current visit would have detailed understanding of that 'contact'.

Two visits were done following the morning medication rounds to a number of patients. All visits except one were with care coordinators; the only exception was the visit by the support worker who generally did not undertake care coordinating responsibility in the team. On two visits there was direct evidence of staff actively seeking to address patients' emotional issues. On one occasion the visit was a CBT session focussing on patient's written account of events earlier in the illness and on the other, there were elements of the separation work between the patient and his mother. Most of the visits elicited information about patients' involvement with their relatives or friends. However, the staff focus seemed to be on supporting patients with tasks to ensure that they remained out of hospital, without much concern for their quality of life in the community.

I entered behind Gillian (CPN) into a dark corridor and was hit by a strong stale smell: Gillian continued into the living area, treading carefully so as not to step on the stuff on the floor. I was in front of the kitchen door and Anton (SW student), who was also with us, had gone into the kitchen and immediately started looking for something to wipe the worktop as he muttered that he would put the kettle on to make a cup of tea for Andrew (patient). The walls of the kitchen were sprayed with some brown stuff and rubbish was strewn everywhere. Gillian introduced us – Andrew ignored me but said he remembered Anton from last week when the latter had visited with another staff. Anton shouted a greeting saying that he was going to make him a cuppa, and Andrew grinned saying 'that'll be nice'. Anton pointed to the stains and said that was dried blood, Andrew hurt himself a lot and had a lot of open wounds, he was diabetic but neglected himself so was very vulnerable. Gillian had also told me that the neighbour, a young man, exploited Andrew by borrowing money while pretending to be his friend and helping him. Gillian was asking a question, trying to elicit from Andrew if he had been visited by the district nurse and whether he had managed to get his medication from his GP. Andrew was skilfully elusive as he asked her if she had got him a replacement bus pass. Gillian was preparing an injection as she said that she had sent off the application form but they had queried whether he had genuinely lost the last one, she chuckled as she told him that they suspected that he had sold it, she gestured offering the depot injection. Andrew muttered something as

he came near her and thrusting his side pulled down his trousers so she could inject his hip, he continued to talk incoherently and I could not understand him. Gillian asked him some other questions but he continued to speak without making much sense to me.

During these visits, staff sought opportunities to discuss patients' compliance with medication, irrespective of whether they were self-medicating or receiving depot medication. Side effects of medicines and other symptoms suffered by patients formed a constant topic for discussion, both with the patients and in the staff feedback about their visits at the morning meetings. All the visits contained discussions about meeting with the doctor and all except one of the community visits attended by care coordinators took this opportunity to set up times for the next CPA review. Discussions also centred on arranging for practical tasks to take place, such as financial issues like accessing benefits/money and goods and paying bills, legal issues such as getting advice and arranging to gather and submit documents to the Home Office, housing issues such as preparing for moving, shopping, cleaning and maintaining the accommodation and attending the monthly group activity. Complaints from neighbours and about neighbours from patients were another topic of focus during the visits. When patients lived in staffed accommodation, contact was routinely made with the hostel staff both before and after seeing the patient to discuss concerns.

Staff Skills

Interaction with patients during the visits showed a tendency of staff to normalise their relationships. Staff shared a degree of personal information with patients, both as a 'friendly conversation' and also to support a point that was being made. They seemed to gather information about those topics which were of particular interest to the clients and had very informative discussions with them on a wide variety of subjects. Staff also paid attention to trivial details of patients' lives, to pick out small achievements and pay compliments to them. The joy experienced by staff was evident in their appreciation of patients' abilities, irrespective of the magnitude of these achievements. This attempt at

social inclusion by getting patients interested and involved in matters beyond themselves and their illness was a general practice amongst staff. Patients were given detailed information and their opinion and agreement constantly sought in making even nominal decisions about their care. When patients complained that their understanding of their care was different to what was happening, staff listened attentively. They did not argue or try to produce evidence to prove that the patients were mistaken; instead just a straight forward apology was given on behalf of the team. Their sympathy with the patients seemed to stem from their view that even with the huge number of team structures to ensure shared understanding of patients' situation and care plans, there was still a potential for information to be lost or misinterpreted. Staff enquired after the patients' activities whether it was cricket or gambling, they seemed to be interested in discussing these from the patients' perspective, showing little evidence of their own outlook on the subject. Patients seemed to have some control over what was discussed during these contacts despite the fact that staff were conducting a series of routine checks, such as asking after their biological functioning, e.g. sleep and appetite, checking dosset boxes for medication, asking about how the patients were spending their time and what was happening in their relationships, mostly in a non-confrontational manner. However on some occasions, when the patients seemed reluctant to engage or continue the visit, staff stood their ground and assertively continued their interview, pushing the limits of their relationship. Under these circumstances, the skill required to complete these checks, whilst remaining alert to the patients' temperament and keeping the focus on the patient's issues, was paramount to their relationship with these patients.

Staffs struggle to keep up this level of patient-centeredness and self-awareness was evident during the visit on the ward with Marcus. Patient Greta was unhappy about being woken up from her afternoon nap, despite the fact that he had agreed the time of the visit with her. Marcus allowed Greta enough time to get comfortable with a hot drink and a smoke before commencing the interview. The interaction started amicably with Marcus enquiring after her, but Greta seemed irritable and preoccupied with wanting to go home. Marcus asked about an incident of fire setting and the patient started to shout her innocence. Marcus seemed oblivious to the reaction he was causing – he continued to

introduce controversial topics that provoked increasingly more resentment in the patient, until she was beside herself with rage and the potential for violence become untenable. An excerpt from the visit account reveals staff becoming immobilised by the fear evoked by the patient's uncontrolled fury but then recovering and taking effective control of the situation:

Marcus tried to intervene by saying 'Greta please stop screaming' a few times, he seemed ill-at-ease and I wondered whether he was saying this because he was embarrassed by my presence and whether this would only inflame her anger more but it did not seem to have much effect on Greta, whose raised voice had reached a pitch where her words were rolling into one another making it difficult to decipher them. Greta had worked herself into a senseless fury and seemed unable to continue the conversation. She was making gestures with her fists and punching the air in front of her while (I think) describing what she wanted to do to Marcus. I was on alert as I watched her body, wondering if we would be able to contain her should she attack him – I took a quick look at Marcus, whose face was blanched as he stared at her entranced and now completely oblivious of me. Greta was gritting her teeth, her body had tensed and her chest was heaving. Her voice was slurred as she continued to scream abuse and threats at Marcus. I had been unable to follow her ranting and I was not sure whether Marcus had, but he suddenly came to himself and said, 'Maybe we should stop now and end this meeting' Amazingly Greta heard this and saying 'Yes' stood up – her demeanour seemed to change completely as she calmed down suddenly, her hands were by her side, though her face was still contorted. Marcus darted to the door and opened it – she continued to shout as she walked out of the door. Marcus came back and flopped down on the sofa with relief.

We had arranged for me to interview him following this patient contact. When I asked Marcus how he felt, he said that had been close but he was alright. He would discuss the incident at the team meeting the next morning. He felt sure that his colleagues would be sympathetic and they would also contribute from their own experiences with this patient so that a decision would be made whether this was her usual behaviour or whether she

was relapsing. In addition to evidencing his ability to take charge of the meeting with a very irate patient, it also demonstrated his reliance on the morning meetings to get support and some perspective on his experience, emphasising the importance of the team approach to staff in this team.

A majority of the patients on the caseload of this team have both a dependence on illicit drugs and a tendency to violence which is driven by their chaotic state of mind. There is considerable danger to staff if they are not constantly aware of the patient's preoccupations and conscious of how their own responses may be received by the patients. The need to mould their responses to encompass this understanding of their patients' mental state and labile moods is vital in maintaining the safety of the situation.

Countertransference

Twelve out of the fifteen patients seen during these visits seemed to be too unwell to be conscious of their appearances or that of their spaces – their struggle to manage independent living was evident in the strong and unbearable smell in their lodgings, the mountains of dirty clothes strewn everywhere and the invariable absence of linen on their heavily soiled beds. The flats themselves were strangely devoid of any signs of cosiness, even when there were sofas available they were like strange islands which did not seem to be used by the patients themselves. Some of these sofas were piled high with dirty clothes or other unusable kit, such as masses of wires and paper and broken bits of equipment. There was invariably one clear sofa with no stuff on it, as if it was there solely for the use of staff from different agencies who visited these patients. None of the patients talked about music but one thing common to all the accommodation visited was that each of them had several music systems strewn about, thickly covered with dust as if they were not in use.

Most of the patients were socially withdrawn and had isolated themselves – they sometimes talked about contacts they had with other patients. Most of these contacts took place outside their homes and details were often elicited of how they were they were taken advantage of. Their surroundings seemed unimportant to the patients and were

ignored by staff, who seemed oblivious as they sat on the beds or the sofas whilst carrying out these visits. During the interaction, patients did not usually offer eye contact with the staff. When I was introduced as shadowing the staff, patients cursorily acknowledged me or completely ignored me. In addition to the background information given by staff, I was able to recall information from the discussions about these patients in the clinical meetings. Nevertheless, I was still unprepared for the appearance of some of the patients we visited. The following is an excerpt from a visit with Peter:

Peter asked Richard if he had seen his sister and whether his sister was still in the cleaning business. Richard mumbled, slightly shaking his head – Peter said ‘so you are not doing any work’ and again there was a mumble. Peter said that it was good if she could find him some work once in a way because it got him out and got him some cash – Richard asked about a scheme saying he had heard that they paid to attend it – Peter clarified that he would have to attend training for a few weeks before they would find a placement for him and then he could make some money – Peter paused as he thought and said - it is not a lot of money so it wont effect your benefits but it is cash – Richard shook his head mumbling that he did not want that – Peter suggested that perhaps he wanted cash in hand and did not fancy working for nothing for a few weeks – Richard grinned as he looked at me and rolled a cigarette – Peter started saying that perhaps he should get his sister to find him some work and then suddenly realised that there had been no introductions so he told me Richard’s name and told Richard that I was shadowing him today. I had been looking around the room and sometimes at Richard, wondering how reasonable he sounded in contrast to the way he looked and lived. I wondered if I would be frightened of him if I was to meet him in a deserted alley and whether people on the streets and children in general found him intimidating – I thought about why I would be scared and wondered if he knew he had this effect on people and whether he would play with the idea and try to frighten people on the streets by going near them and making a noise or doing something really weird and scary – I was trying to remember patients I had worked with and whether I had ever been fearful of approaching them either as a MH practitioner or on the streets. I suddenly felt affection towards him and decided that I would have

strived to engage him and enjoyed working with him. It felt natural for him to show an interest in me. I introduced myself and told him that I was observing Peter today – he seemed slightly interested as he asked me what exactly I did – as I started to explain, he lost interest, nodded and looked away, drawing on his cigarette.

This profound change of feelings towards the patient which occurred within a matter of minutes in my mind seems to reflect or indicate the kind of feelings that these patients evoked in the staff.

Staff Interviews

Of the nine staff who participated in the visit observations, interviews were completed with eight; the ninth cancelled several times and hence it was not possible to complete the interview. Interviews with each of the staff were arranged after their visit had been observed. Participating staff came from a wide variety of professional backgrounds but identified themselves as carrying out the role of mental health workers with responsibility for co-ordinating the care of their patients. Further elaboration of their day-to-day work elicited a wide range of tasks, 14 of which could be grouped under day-to-day social care, 7 under monitoring illness, 3 under emotional support and 2 under liaison. This focus on practical over emotional issues confirmed findings of the visits and the team meeting observations. Staff spoke of their various interests outside their work and there was general consensus about being influenced to work in this team by the nature of the patients, the supportive structures in place within the team, the kind and sympathetic management and most importantly that it was innovative and exciting. Staff, who had a wide range of previous experiences, deeply appreciated the encouragement to undertake further training courses in accordance with their professional development plans and took responsibility to ensure that there is a wide range of skills available within the team. The team had attended intensive training to gain a psychodynamic understanding of the patients and also to start examining their own individual motivations for undertaking this work and an external group conductor regularly facilitated discussions of their concerns. The manager, who had completed post-qualifying studies at the Tavistock, viewed both

the patients' difficulties and his staffs' drive in terms of attachment theory. Whilst being deeply influenced by this theoretical thinking, he also appreciated contributions from the systems theory, CBT and other interests of individual staff, and ensured that there was ongoing training available for them.

Patient Characteristics

The team works with a caseload of 92-93 patients, offering a range of psychosocial skills and working beyond normal professional boundaries. Apart from being impressed with this model of work, staff unanimously spoke about being influenced to work in the team by the challenges presented by the nature of the patients. Patients were described as having complex needs, including dual diagnoses, being socially isolated and withdrawn, institutionalised, hard-to-engage and having a tendency for violence. The model of work, with its focus on a holistic approach, allowed staff, irrespective of their professional backgrounds, to be flexible and get involved in those aspects of the patients' lives with which they were struggling. Staff understanding of the patients' characteristics and behaviour is summed up in the following excerpt from one of the interviews:

I wonder if that is something that happens a bit - that people feel that they are –that they kind of failed not only normal society but that they have also failed the mental health system – and so – they do feel that things which highlight their failures are really painful. We've realised that they need to attach to people – that throughout their lives they haven't been – through their childhood awful things have happened to them and they haven't been able to attach to anything and so therefore they haven't been engaging with help either and what this team does very well is be there for them – be reliable be consistent and have a bit more time and it works –even if the patient's care coordinator is sick for a week there will be someone else to see them so that there is this level of involvement and they can rely on us and sometimes it really might not work with people at all but they have the lived experience of being able to rely and trust someone possibly for the first time in their lives -----

Building up a knowledge base of the patients' characteristics and experiences which is stored in the memory of the team offers support to staff who are struggling with particular experiences. This also facilitates their trying out various approaches in helping the patients whilst coming to terms with their own feelings.

Staff Qualities

Except for two unqualified staff, most staff in this team have been employed because they have the required professional qualifications. However, both the manager and deputy asserted that the most important qualities they looked for when recruiting staff were:

The ability to think first of all and the ability to share -- and people who are not afraid to learn, - people who are able to take risks.

This need to have a conscious understanding of risks and to share the responsibility was further emphasized by describing the original staff group (before the current manager), which had many unqualified workers and a distinct difference in responsibilities between qualified and unqualified staff. There had been a murder by one of their patients and the team were highly sensitised to risk following a homicide enquiry which had left staff approaching each task with a paper trail to cover their backs; all qualities that '*did not lend themselves to the task of working with this group of patients*'. On joining the team, the preliminary task that the manager undertook was to make the team much more accountable with a cascading supervision model, so that people were tasked with bringing colleagues through difficulties and everyone was looking out for each other. The newer staff had less community experience, as most of them were either freshly qualified or came from a background of residential care but were more firmly attached to the organisation. The manager said:

The task is to form a bond – to help the service user to attach to the team so that the team can use a whole range of psychosocial interventions to ensure that people's lives are a bit better - to cut down the chaos - the drug use, reducing the use of beds

and encouraging meaningful stuff to do during the day - if staff feel good and equally feel a sense of belonging and if they've got that, they give that to the service users.

One of the important demands on staff is not to personalise their failures. Staff emphasized the need to celebrate small achievements whether it was gaining access to a resource for the patient or a miniscule improvement in the patient's illness and behaviour as they strived to achieve social inclusion for them. Being able to go outside their own areas of expertise and gather information and learn new skills in order to address patients' needs was a requirement of working within this team. Flexibility both in terms of their professional boundaries and in their daily time tables is as important as developing personal qualities such as patience, endurance and perseverance. Being creative about engaging patients and separating personal from professional issues, in order to always be available to patients irrespective of personal preoccupations, is crucial. Staff pointed out that their own ability to do that was because of the nature of the team:

Within this team, its really good actually, everyone seems to get on really well - well they do and they have and if ever you've got any issues of concern then you can go and talk to pretty much any of them and they will sit down and discuss any concerns or problems that you have and I find very often they come up with solutions – suggestions that helps – you get regular supervision which is a good thing there's a social side to work as well – unusually we go out quite a lot I think compared to a lot of wards I've worked in and other teams I've worked in - you cant wait to get away from the working environment at the end of the day but with our team, people like to socialise and spend time on occasions and that's nice – its refreshing, but we also hang out after work to discuss if something is bothering us so you don't have to take it home or wait till the meeting tomorrow morning -----.

It is imperative that staff have the ability to elicit support by making contact with individual colleagues and also bringing their experiences to the team meeting. It is not necessary to have complete clarity as to what they were asking for but it is essential that they are able to express their discomfort and allow the team to think about the meaning of their experiences. Taking an active interest in their colleagues' experience and

participating in understanding its meaning and contributing to the plan of action with the patient is equally important as being able to accept the shared decisions and undertake tasks with patients that are jointly agreed with the team irrespective of whether they themselves concur with it. The total focus on patients while developing a team identity at the cost of forgoing individual and professional identity is as important as participating in team training and ongoing professional development.

Stressors and Supports

Patients who are referred to this team are those who have been rejected by other services due to the difficulties involved in engaging them with treatment. This team concentrates on getting them involved in activities of social inclusion through frequent contacts at times and venues suitable to the patients. The well researched support structures put in place within these teams are indicative of the recognition of the stress inherent in this work.

Staff spoke consciously about three areas of stress. These included: a) illness-related issues, such as dealing with delusions and aggression, experiencing the helplessness of witnessing the gradual self-destruction of patients who are dependent on street drugs, observing patients gradually relapse, having to initiate hospital admissions and especially arranging Mental Health Act assessments; b) patient behaviours such as aggression, violence, manipulation, complaints and other impulsive actions including anger, abuse and nastiness; c) demands on staff, such as needing to be unconditionally available to patients, lone working, facing criticisms from staff of other services, not having enough time to do everything and coming to terms with the limitations of working with this group of patients. Describing the stress in the work, one staff (OT) said:

When you feel you are not getting anywhere that's difficult - when sometimes we feel like we do a lot of work for people – this sounds really selfish – but it is something along these lines – I don't blame the patients for that but you might have put a lot of work into something – for example this patient, for a long time she was very angry with me and very critical of me for not helping her move and find some supported

accommodation -- I was really trying – I was doing a lot of work and found somewhere and helped her go to an interview and she had done quiet well and actually throughout the process she was making a lot of complaints to the hospital and to even higher authority – some national NHS complaints man rang me up and accused me of neglecting her but when she sort of got this place and right at the end – few days before she was due to move in she just said 'I don't want to go – I'm not going' - its things like that sometimes without anything in particular it feels like - its not that you want to be thanked for the work - its not to do with gratitude but somehow it feels that its hard and all the work you do has come to nothing – I've heard people talk about -- it hasn't happened to me but they do a lot of work – writing to charities and getting a lot of money because this person will be able to buy some new clothes because they haven't got any clothes or their flat is in a terrible state and maybe they will be able to give them a new cooker or curtains and the person just goes and blows it all up on drugs and its just like – its so disappointing – that's the hard part – well that is hard.

Staff talked about their colleagues as being their major source of support. During visits, it was not unusual to observe staff talking to their colleagues on the phone. Staff said that sometimes when they had really awful experiences, they would arrange to meet with a colleague for a 'drink and a chat' at the end of the day. 80% of the staff in this team are in their thirties – perhaps this assisted the culture of frequent team outings with the aim of facilitating bonding between staff and enhancing communication between them. The walls in the team office are covered with photos of these outings with playful captions displaying an easy familiarity within their relationships. Because knowledge about patients is shared within the team, it appears easy for them to gain support from each other by discussing minute details of their experiences with the patients. Though the observation of the team revealed that there are some staff who do not completely participate at this level of 'bonhomie', there did not seem to be any tension between staff as they asked each other for information, advice and small favours. All the interviews extolled the supportive nature of the clinical meetings. The opportunity to share historical knowledge of a particularly difficult patient and also elicit the team's memory of better

times with that patient facilitated the shared responsibilities of the team approach. This contributed to their enthusiasm for the work and to enabling them to continue giving it their best. This meeting that occurred every morning to plan for the day and Friday evenings to plan for the weekend was described by the psychologist as:

I think it's the team approach that helps us that you can just – because we have these great systems – processes – meetings every morning - to be able to just say this is happened - to the team for everyone to say 'oh no – that is terrible' that enables us to deal with that really – because I think it prevents you from blaming the patient -- because that's what we cant do and I don't think that we do that - we can feel disappointed and frustrated but we deal with it by kind of sharing it and thinking about – sort of formulating with – sometimes – like – you might think about the person and the drugs and the money and its – maybe they have never had anything in their lives – you know they have never had anything given to them and it feels so foreign that they kind of sabotage the experience - I suppose in thinking through and I think that the team approach really helps that as well because if it has just happened to you as an individual worker or someone - it is much easier to get drawn into a – sort of feeling – taking it personally and feeling angry with the patient but being able to talk about it in the team that allows you a bit of a distance - to look back – to step outside and look back as to why did this happen – the team helps you do that in the meeting.

The structure of this meeting as described above was geared towards facilitating both the sharing of responsibility and keeping an up-to-date knowledge of patients through frequent visits and discussions. Staff paired up with their colleagues to visit patients whether they were doing initial assessments, targeting certain issues, offering particular interventions or doing assessments for admission to hospital. Formal structures such as the medication rounds and weekend cover also required that staff work in pairs. Fortnightly supervision of staff as prescribed in the DH Guidelines for this type of team were strictly adhered to and staff said that they were comfortable about asking for it as and when they needed it. Staff described supervision as facilitating reflection and

introspection of both personal and work related issues, helping them to become aware of and consciously use personal issues in helping patients and also putting experiences into context and not to personalise them.

In trying to think about what it is like to work in this team, staff expressed deep appreciation of their colleagues as they compared their personal experiences and observations of other teams. They appreciated the opportunities to socialise informally outside of work and also described at length, the relative lack of stress in working within this team. The following are excerpts from two different interviews:

I think its good to be associated with this group of people and I think that they probably think that they – people are going places – they are doing things - it's a challenging place and we have a very good reputation with universities and students have a very good placement here – learning experience here - and there is a clear role for the student and there is a clear teaching role and I think it's a good laugh at times - I think you have a good laugh and probably people will have a spectrum of feelings towards what they do - sometimes they probably hate it as well and find it too much - too demanding - but I think overall I like to think everything is positive.

And:

Erm, I love working here – I just think its such a great team – I can't imagine there being a better group of people to work with really and I think that makes such a big difference – the fact that we get on but that we do challenge each other and we do disagree about things, but I sort of look forward to coming to work because I know I'll have good company – sometimes when I have too much time off from work, I get a bit bored – I sort of look forward to coming to work and seeing everyone and its constantly changing like - what's happening with the patients is changing all the time and – its like some ongoing soap opera or something – what's happening with so and so – there's never a dull moment – there's always something happening – I think the team are really supportive and everybody recognises that the job is stressful and they recognise that people do it differently and you know you are allowed space for that

you are allowed to be stressed or upset and you are allowed not to cope very well if you can't cope very well.

Inferences and Organisational themes

Hinshelwood (1998) point that:

'the job of containing psychosis is performed by the whole of the personality of the worker – one's capacity to feel, empathize, worry, get a little mad oneself, reflect and in the end do one's best to place oneself alongside the client (and incidentally colleagues)' (p24),

How do staff place themselves alongside the clients and their colleagues - what actually happens in these teams, how do they contain the psychotic projections from patients; and what resources staff draw upon to continue working effectively? To understand these questions, ideas are drawn from both the systems and psychodynamic theories.

The Team as a Social System

The mental health system encompasses a wide range of services, from GPs at the primary care level, to the hospital beds and teams for follow up in the community at the other end. This team is at the extreme end of this spectrum – as it takes patients who have frequent admissions as they cannot live/resettle in the community because they need a lot of support to do so or because they are unable to engage and accept ongoing help to remain in the community. All the referrals come from other specialist mental health teams and consist of people who have been ill for a very long time. Most have been abandoned by other teams due to the complexity and intense demands of caring for them. Many of the patients have been through the 'system' and so come with various 'experiences' of it, which further hamper their engagement with staff in this team.

In this team, staff are drawn from both health and social care backgrounds so that the team is set up with funding from both local health and social services. It comprises skills to address all aspects of the help that patients may potentially require. The clients have

some form of accommodation in the community which could be staffed or unstaffed and, by being able to respond quickly and intensely, the team identifies signs of relapse and address them reduces the chance of clients needing hospital admission. Staff encourage and accompany patients to make use of community facilities with a view to reducing social exclusion and getting them engaged in the community. Though the team's operational criteria stresses that staff have up to two years to achieve the successful engagement of patients with mainstream services, in reality this arbitrary time limit barely affords a preliminary rapport to be built with many clients. As the ultimate service to help patients remain in the community, the AOT uses all the facilities available in the community, including short term admission to hospital. It can only refer patients back to mainstream services when they are ready to live in the community with only the less intensive support that those services can provide.

Primary Task

The team has been set up as a further development of secondary mental health services to address the needs of those patients who fall through the net of the usual community services, resulting in rapid relapse and frequent admissions. The unrealistic expectation of addressing the economically unviable revolving door phenomenon is the *Normative Primary Task* of this team. Constantly negotiating with other services and redefining the limits of its own clinical expertise, while enduring the pressures of demands from senior managers, the team continues to strive towards the social inclusion of its patients. The data from staff interviews indicates the team believes that it has been set up to ensure engagement of patients and minimise their resistance to treatment. Staff aspirations of improving patients' compliance and ensuring their survival in the community is the *Existential Primary Task* of the team. However, observation of the preoccupations of the staff and the team structures reveals a focus on patient safety. Monitoring medication and ensuring the health and safety of patients through liaison and focusing on practical tasks is the *Phenomenal Primary Task*. These explicit objectives and implicit expectations of the team are congruent and remain focussed on maintaining the patient at the centre of its attention. By creating a dialogue between the different subsystems,

both within the mental health service as a whole and within its super-ordinate, subordinate and environmental systems, this team has enhanced its function of containment both for clients and staff.

Basic Assumptions

The team has tried to contain the primitive anxieties evoked by the fear of becoming infected by the patients' diseases by encouraging an inter-relationship between staff both at work and outside. The freedom to discuss their worries and experiences with each other, promotes the effective achievement of this task. Empathy towards the patients and their struggles with both the expectations of other services and the limitations of their own roles bears the tendency for baP between staff and patients. This pairing is essential to achieve some successes and enhance the effectiveness of the team. With the manager playing such a major part in supporting staff and having an overview of both the team and its links with other services, it is imperative that staff are dependent on him. A team approach is also highly likely to cultivate a sense of dependence on the team. However, this dependency is not so dysfunctional that staff are unable to function independently. Putting in place structures such as the cascading supervision system, the sessions at the Tavistock, the ongoing staff support group and constantly using these insights in staff interactions, the team has strived to gain self awareness and keep its focus on patient care, without dwindling into a dysfunctional baD. Dependency also lies underneath the rejecting behaviour of the patients, and the team approach emphasising attachment is also carefully set up to minimise patients' dependency which may otherwise make their relationship with staff less effective. This awareness and the conscious use of basic assumptions pairing and dependency is functional within this team.

Social Defences

The primitive anxieties inherent in working with the deadness of withdrawal and rejection constantly faced by staff evokes infantile phantasies of annihilation. Such powerful feelings are countered by developing psychological defences in order to maintain the sense of equilibrium required for day to day functioning. In this team several structures

have been established to counter these infantile anxieties, such as the ongoing reviews of patients, daily medication rounds and joint decisions and contacts. Phantasies that madness is potentially infectious are contained by curtailing the duration of encounters by arranging only short visits. Other structural aspects of the team, include the boundaries and the transactions across them, the nature of work tasks that the team is engaged in, the levels of authority vested in the manager, and the processes and activities that make up the primary task of the team are also carefully set up to address these unconscious needs and diffuse the fears invoked by realistic and imagined risks. This way of managing the relationship with patients in predictable and extremely planned ways offers effective containment for these unbearable anxieties. Fragmented care offered by short visits by different staff at different times is a potential defence against too much exposure, but the expectation that all staff must have up-to-date knowledge about patients and should implement joint team decisions, may render it functional by reducing the anxiety of sole responsibility for staff while also offering continuity and care for patients. In considering the practices within this team and its primary task, the complexity of providing good enough care is enhanced by the social systems, since they are thoughtfully set up to include reflective spaces to deliberate upon their experiences and make use of the resulting insights.

Projection, projective identification, splitting and avoidance

Despite all the defensive structures within the team, primitive processes such as projection and projective identification continue between individual patients and staff. Essential as they are in understanding the patient's internal reality, these processes have the potential to distort the staff's own inner reality and lead to the invasion and control of their mind rendering it unable to think freely and objectively.

The nature of psychosis is such that it pervades the whole personality of the patient, the lack of insight coupled with the strange mental encounters restrain the articulation of these experiences rendering them non-verbal. Communicating this emotional anguish without conveying the actual meaning of these experiences has a strong impact on staff

and containing such powerful processes in turn requires the whole personality of staff in addition to skills, knowledge and an awareness of both the self and the influences of these processes. The affect created by the introjective identification of staff with the patients' deadness or absence of liveliness could effectively immobilise their functioning and render them ineffective. Additionally, there are the projections into the staff from other agencies of their own disappointments at the relative lack of progress of the patients. A process of primitive splitting between the good patients and the bad agencies occurs in the attempt to remain loyal to the patients and preserve their relationship. This resulting despair in staff could easily lead to the team becoming collectively demoralised so that they cannot give each other support, encouragement and praise as they feel that they themselves are not doing a good enough job. The reflective spaces they have are essential in examining these feelings of helplessness and despair, and collectively to repudiate these experiences and locate them where they belong. By constantly questioning the processes, examining new ways to understand them and developing techniques and skills to address the negativity and doubt, the team successfully reduces the risk of staff succumbing to these processes and falling into a mindless routine.

However, the stark avoidance of certain issues is evident in the use of humour to mask fear and to evade discussing its impact on staff. The team depend on these humorous interludes to seek relief from relentless discussions about the painful existence of their patients. Another area that is completely absent in the team's consideration is the sexual needs of patients. This was not touched upon by staff in their visits nor was it mentioned in their interviews. In the clinical meetings, patients' utterances of a sexual nature were treated as a relapse signature needing immediate assessment for admission. In a team that prides itself on getting involved in every aspect of the clients' lives, this reluctance to deal with certain issues could be seen as avoiding matters too close to the personal struggles of the relatively young staff group.

Conclusion

This team fulfils the requirements of the classic model of assertive outreach in mental health, both in its structure and function. While patients are helped to achieve some stability in the community, staff are also thoroughly supported to maximise the use of their skills and continue their professional development. Managers in this team have successfully integrated the internal and external expectations by establishing meaningful structures to develop caring relationships and process the painful feelings evoked by these patients and the demands placed on them by society. However, the continuing pressure of keeping to the primary task of preventing relapse and resettling the clients in the community leaves little time to concentrate on enhancing the quality of their lives. Given the nature and severity of the clients' symptoms, the likelihood of 'cure' or even significant improvement is extremely remote. As a consequence, in order to work in this field, the staff have to deny this and highlight smaller achievements, in a bid to preserve their own sense of purposiveness and avoid demoralising feelings of failure. Funding agents measure the success in this team on their ability to prevent hospitalisation. However, another indicator suggestive of its success is the low levels of staff turnover and self-reporting of the small amounts of stress experienced by them.

Chapter 5:

The Community Mental Health Team

Introduction

The Community Mental Health Team (CMHT) was the last team to be observed in this study. It is a typical representative of mainstream secondary mental health services that link primary health care to specialist mental health care. Like many of its counterparts across the country, this CMHT started life as two groups of staff and managers separately employed by the health and social services. Following the publication of the Community Care and NHS Act in 1990, Social Services set up teams to address the mental health needs in their communities. Health Services too had small numbers of staff identified to offer support to patients on discharge from hospitals. Several pieces of legislation followed in the next 12-15 years which increasingly gave the power to these two statutory authorities to contribute towards an integrated mental health service that would fulfil these statutory duties. These culminated in the development of the integrated CMHT. Thus, after a short life as two distinct teams, staff were brought together into a shared office under a single manager appointed jointly by the two employing/funding authorities.

Based in a busy inner city area, this team works between 9 am to 5 pm during the working week and is supported out-of-hours by the 24 hour Crisis and the Home Treatment Teams. The team includes staff from each of the relevant mental health disciplines, such as medicine, social work, nursing and a part-time psychologist. The deputy manager is an occupational therapist but is not employed for her professional background as there is no OT post in this team. By virtue of its location, this CMHT also has access to an extensive range of resources, including 24-hour staffed residential crisis units, day centres, training and employment agencies and a wide variety of short-term and permanent housing projects with differing levels of support. All staff identify

themselves as care coordinators offering generic mental health care to patients, although they also incorporate specialist duties related to their disciplines, such as mental health assessments. In addition, individual staff take responsibility to link-work with relevant services such as GP practices.

Every day one front-line staff member is on intake duty, to offer consultation and take new referrals. They are in turn supported by the senior member on duty, who is available to accompany them for visits. The seniors also take responsibility for following through and gathering further information on those referrals which are incomplete. Once all the information is gathered, they are taken to the referrals meeting where they are examined by the consultant and the manager and decisions made as to whether they are suitable for further work or need to be referred on by senior staff. Despite this careful scrutiny, a large number of referrals are allocated to the front line staff for a comprehensive assessment. All initial assessments are completed by two staff from different disciplines, so there is a multidisciplinary perspective. Assessments consist of interviewing the patients and collecting information from all the sources indicated by an examination of the facts as they are gathered. Completed assessments are presented to the rest of the team at the clinical team meeting and a joint decision made as to how to progress with individual cases. This might be short-term allocation to a care coordinator for a targeted piece of work, such as accessing housing or longer-term work and ongoing care and support. Patients are put on the Care Programme Approach Register and a care plan drawn up to address their needs. These are reviewed at regular intervals to ensure their ongoing relevance and to gauge the resulting effects on the patients. Patients who do not cooperate in addressing their needs are discharged if they continue to cope in the community. If the non-compliance results in repeated admissions to hospital, then they are referred to the AOT. The team uses several other projects such as the DBT⁴ groups, the Prison In-Reach Team and the Drug and Alcohol Service to help in caring for their patients. Despite the availability of these additional services, the onslaught of referrals is such that there is constant striving to keep the caseload to reasonable levels by adhering to strict entry/exit criteria. Those patients who remain on the team's caseload are

⁴ Dialectical Behaviour Therapy groups run by the local psychology service

regularly reviewed during supervision and those who give rise to questions about the effectiveness of their care are further deliberated upon at a meeting between the manager and the consultant. These elaborate procedures are followed strictly in order to ensure that inappropriate cases do not clog up the team and hinder it from effectively addressing the needs of more suitable patients and also to prevent staff burn-out through overloading.

Emerging Themes

The four sources of data for this team, as in the others, came from observing 6 weekly team meetings, 10 observations of staff visits to clients and 11 interviews with staff and from 6 staff feedback forms, in addition to the information on the team questionnaire.

Volunteers who took part in the study included the manager, the deputy manager, one of the two senior social workers, the consultant and a number of frontline staff, like the psychologist, social workers and CPNs. Apart from the manager, who does not do ongoing frontline work, all staff were first observed doing a visit to one of their patients and then interviewed. Each source of data is described briefly and themes identified in them. In describing the themes, excerpts have been used mostly from that set of data but sometimes from other sources of data within this team.

Team Meetings

In this team, a weekly clinical team meeting is held in addition to the 10 minute meeting every morning to discuss the plans for the day. The clinical meeting is more formal and attended by more staff and lasts about one and a quarter hours just before lunch on Tuesdays. The key purpose of this team meeting is to facilitate patient well-being by ensuring that all new assessments are discussed, concerns about existing patients are considered and shared decisions regarding patient care are facilitated so that it is not entirely dependent on individual staff. All the senior staff endeavour to attend this meeting as do all staff, including an administrator who takes brief notes of the proceedings. However, it was observed that some staff consistently avoided it by

prioritising report writing or arranging a formal Mental Health Act Assessment to coincide with this meeting.

The team shares a 'U' shaped open-space office with another CMHT, and has small private rooms for the managers, deputies and consultants. The meeting room is a conservatory which leads out of the main office, with glass covering the entire upper walls and ceiling. It is very hot on sunny days and cold in winter, especially as the heating is archaic and beyond control. In the middle is an oblong table with 12-15 chairs around it. The walls along three sides of the room are stacked haphazardly with filing cabinets, cardboard boxes, piles of files and spare chairs. The fourth side is a glass partition stacked with shelves holding information about all the resources available in the area. Little gaps in the shelves show an enclosed garden with colourful flowers which often involuntarily drew my eyes during the meetings.

The meetings are chaired by senior staff in rotation and have a loose structure consisting of feedback regarding the patients discussed the previous week, presentation of new assessments, consideration of information about formal Mental Health Act Assessments that had taken place the previous week and those that are expected during the next week. Each staff takes turns to discuss concerns about their patients, followed by feedback from staff linking in with other services and from the crisis team representative. On rare occasions, structural issues are considered and decisions made, such as setting up clearer systems of communications between the junior doctors and care coordinators or adapting Trust procedures into team practices.

A majority of staff referred to this meeting as being important in eliciting support to perform the duties that their role required within this team.

Nature of Clients

This team takes on an array of cases, both for short-term and long-term support and care. Though there are clear government guidelines to prioritise patients with severe and enduring mental illness, many of the cases taken on for shorter term work are people

suffering less severe illness but who are unable to sustain themselves in the community. Getting involved to settle them and help them access services aims to prevent chronicity developing and the need for long-term care. Following the completion of the identified tasks, patients are efficiently discharged with the understanding that they could be referred back should their circumstances change. There is a lot of knowledge about patients and resources built up over the years and even the memory of discharged patients is often elicited when they are re-referred to the team. Presentation and discussion of the new assessments completed by staff within the previous week takes up about 60% of the time of this meeting. A typical example of the discussions at the presentation of a new assessment observed was:

Petrina (SW) presented the next case of a 23 yr old man referred by his GP with a 3 yr history of depression which has got worse in the last 4-5 months since his girl friend left him. He lives in a studio apartment with his large dog and is on Citalopram and is also being treated for high blood pressure. He also takes 5-6 Valium a day to keep himself calm. The GP feels that his anxiety and depression are getting out of hand. Tim (CPN) wondered if he had had any therapy at all. Petrina said that he had had some sessions at the Tavistock who advised him to get CBT as therapy at the Tavi would rekindle his old issues. The Tavistock report also said a number of other things including that he has sporadic contact with parents who abandoned him when he was 17 – he says that the only thing worth getting up for each day is his dog since his girlfriend dumped him. He has lost 6 stones in weight in the last year especially since she left him – Dr Y (consultant) laughed and asked what he looked like and Petrina said that he still looked very fit and handsome – there was a bit of discussion that he had previously been overweight so must have lost a lot of weight. Debi (psychologist) said that she remembered him and had done a report and asked whether her report was in the file – FG(Manager) remembered Debi's work – Petrina who had not read that report wanted to know whether he could be helped with CBT by Debi and asked FG where he should be referred to – Dr Y wanted more information about his Valium intake – FG wondered where he got the money because he certainly needs to be buying the Valium from the street as she could not imagine

he would get that amount from his GP. The question of a short term allocation was discussed – Dr. Y asked for Debi’s report which was brought by Petrina and Debi read from it while Dr Y read the Tavi report. When asked what he hoped for – the patient had said that perhaps psychology would help him to understand his depression. Debi said that he perhaps needed more practical help – maybe motivational and parental push – Dr Y said that he should be seen a few times to get a better understanding – Debi wanted to know how he had gained housing – Dr Y suggested more investigation into his abuse of Valium and a further review – the SPR said that the long term abuse of Valium may be the cause of his depression – Dr Y said that the patient could be referred to his out-patients on a non-urgent basis while someone is allocated to help with the practical tasks.

Senior staff, especially the consultant, are very active in these discussions, greatly influencing the direction that the care coordinators should take as they start working with patients. Patients who do not show up for appointments are discharged and this information is communicated to the referrer and other agencies who have been involved with the patient. From the discussions in this meeting it was evident that patients are referred to this team because they suffer from the effects of depression, bulimia, anorexia, traumatic childhood experiences and other post-traumatic stress disorders, chronic anxiety and panic attacks, personality disorders, effects of chronic abuse, such as racist attacks, exploitation and domestic violence, in addition to those who suffered from long-term psychotic illness, such as schizophrenia and manic depressive psychosis. If they are compliant with medication and able to live in the community, these patients would be routinely managed by their GPs. But in the longer term these disorders invariably affect many areas of patients’ lives making it impossible for them to continue living independently, and thus needing support and care from the specialist mental health services at least intermittently.

Treatment interventions

Assessments are very comprehensive, involving liaison and information gathering from a large number of sources. This is done both to understand the nature and extent of the patients needs and to ensure that these issues are related to their mental health problems.

A third patient was presented by Tim (CPN) - a bulimic woman referred by the GP. She had attended the local hospital and had been prescribed medication and CBT. She said that her bulimia wasn't such a problem but she was too depressed to be bothered. She is Turkish and had come to England at 10 yrs of age. Her mother had been insensitive and had always called her fat. Her parents were divorced and following this her depression and bulimia increased but she continued to do very well academically. However, when she fell pregnant she was driven out by her mother and went and lived with her boyfriend in a neighbouring area. They broke up soon after and she was referred to the eating disorders unit. She had her second child and became depressed again. She was also racially abused by some teenage youth on the estate and has had some frightening experiences – she went to Turkey for a short respite after her child was traumatised by an incident when some white youth poured vodka on her - the police and ASBO⁵ team did not do anything – the child has been referred to a child psychologist by the GP. There is no history of mental illness in the family – she requested a referral to the local emergency duty team so she could get in touch with them as and when she needed. She has applied to do a nursing course but is worried that she will not cope with studies and child care. The police are not doing anything about her complaint; she feels frightened and wants to move out of London. Tim had called the Emergency Duty Team and spoken to a nurse who had taken the details and promised to discuss with the team whether they can work with her and get back to him. The ASBO team had confirmed that she had called but they had not found any evidence. The child psychologist can provide evidence of trauma

⁵ Local Authority team which deals Anti Social Behaviour Orders collaborates with the housing department, police and youth offending teams

– there was discussion of whether she would be okay if she moved out of the estate or whether there is a longer term underlying illness. There was a suggestion that a short allocation would be useful to do all the liaison required – someone else suggested leaving the case open to duty in this team– the team wondered whether she would be dumped on them if they took up the co-ordinating role – it was decided to refer her to the ‘Support Time and Recovery’ worker at her GP practice.

This team is very efficient at matching the needs of newly referred patients with the appropriate resources in the community and disposing cases to the most relevant services. In addition to getting psychiatric care from the medical staff within the team, if patients have psychosocial issues, they are allocated a care coordinator in the team. As there is only one consultant in this team, he holds ultimate responsibility for all medical care, though he is assisted by a specialist psychiatric registrar [SPR] and usually two trainee doctors who see patients in outpatients’ clinics and are expected to get involved in organising the various services that these patients may need, including offering counselling and CBT to them. This study was carried out during the interval between the rotations of the trainee doctors and so I did not meet them.

Matt (SPR) presented a man he was seeing in out-patients who had a long history of instability and anxiety following a serious gang rape in a residential home when he was in his teens. He had managed to get into a stable gay relationship and had set up a company to do make-up for TV and film artists which had been highly successful. Then he had discovered that his partner was having an affair and this had devastated him and he had lost everything including his business and was now living in temporary accommodation. During his heyday he had consulted a psychiatrist in Switzerland who had prescribed him with 5HTP which had stabilised him considerably. He wanted to be put back on 5HTP and also wanted oxygen therapy. He had had brief counselling but not on a long term basis. Matt wanted to prescribe Metazapine to help with sleep and appetite as he did seem very down and complained of all the biological symptoms of depression. He said that he had also suggested some CBT techniques, such as doing one small new thing everyday to

improve the patient's self esteem. He said that he would continue to monitor this over the coming weeks.

Staff are encouraged to use counselling techniques in their contact with patients and the psychologist regularly runs sets of CBT groups in partnership with other staff for patients who are on the team's caseload and also for those who are not taken on by the team because their presenting problems are not severe enough. However, if patients have multiple needs then they are also allocated to a care coordinator who assesses them and compiles a care plan with the patient to address these identified needs. This care plan covers areas such as psychological, social, personal and financial needs, including legal assistance, and is aimed at facilitating and monitoring access to various resources to address these needs.

Dylan (CPN) presented the case of a 29 yr old African-Caribbean woman who had been discharged from the team over 18 months ago as she had not engaged with them. She wanted help to get custody of her 3 yr old child who currently lives in South London with her father. She has weekly supervised contact with the child – she wanted the supervision order lifted and for her to have custody – she was asking the team to do an assessment of her mental health in time for the court hearing in September. Dr Y remembered that she had previously refused to take medication and had demanded a second opinion but had not taken it up after he had made arrangements with another consultant – he suggested that perhaps she wants to go and get an assessment from him now. After further discussion it was decided that Dylan's assessment that she continued to be well and did not need to be taken on by the CMHT would suffice for the court –but if she wanted a psychiatric assessment, perhaps the other consultant would still be open to doing a second opinion report. Dylan agreed to discuss with the client and write a reminder to the consultant and also write to the court – he would give her copies of all these and then wait until the court case to see if she would need any more support before closing the case.

Although generally the discussions in these meetings are led by the consultant, there is a careful balance between the medical, social and psychological care that patients get from

this team. On another occasion the consultant decided that one of the CPNs should organise a CPA handover to the patient's new team in the absence of the patient who had disappeared after he had moved into the new area, so that the file could be taken over by the new team as this patient continued to have complex needs and would come to their attention soon. This team meeting is used by staff to communicate with each other, especially with the consultant, about improvement or deterioration in patients' health and life situations. It is also used to monitor the team's performance targets, such as visiting patients within 7 days of discharge from inpatient care, and of identifying those patients who are eligible for fully-funded after-care under Sec 117 of the Mental Health Act. The meeting is used to warn the team of patients who may be relapsing and plan their admission and to gain feedback from the Crisis Team representative at the meeting and from those staff who had responsibilities for linking with GPs, both in terms of bringing information about new developments and for asking for support with particular issues so that patients could be cared for without being referred to the team.

Support for staff

As a supportive structure, this team meeting was mentioned by a number of staff in their interviews. It was identified as the venue that could be used as a sounding board when staff had concerns about patients. This is also the place to elicit historical and general information to put these concerns into perspective, apart from offering the opportunity to express difficulties in detail and gain assistance from colleagues to deal with patients and with other agencies. The team memory of patients built over many years is seen as extremely valuable, as is the vast amount of knowledge about resources and their accessibility available communally within the team.

All staff get supervision from senior staff and, as well as the CPA reviews, this meeting offers the additional opportunity to appraise the consultant of the patient's situation in detail and gain his opinion and assistance, whether it is in the form of a firm decision to take particular action, or suggestions as to what areas could be explored further or to seek joint appointments with him to see patients. This seemed particularly important to

the team as, on the one occasion out of the 6 observations when the consultant did not attend, many staff decided to leave quite early on in the meeting which itself lasted only a short time. Observations of these meetings also revealed how patients are dealt with when their care coordinators are away on leave. The senior staff who line-managed these absent staff usually covered their patients and brought up issues to the team on their behalf.

Staff also bring problems they experience in team functioning, e.g. one of the senior staff encouraged their supervisees to talk about an issue they had been facing. This was about junior doctors not attending previously agreed appointments with patients and care coordinators. There seemed to be some discontent as non-medical staff felt that they and their supervisors took care to notify patients and the administrator of their own absence. Not unusually, the consultant took over the discussion eliciting the details of the problem and was told that the administrator may or may not know about the absence of medical staff so they could not decide when to cancel appointments – this is especially problematic for CPA reviews as the patients and other agencies attended and waited for long periods before going away not knowing whether the review took place. The consultant decided that henceforth he would ensure that the team administrator had the timetable of all the medical staff – especially the junior doctors - who had long gaps in their availability due to the nature of their rotation within the service, and all absences would be communicated with enough notice so that appointments could be reasonably cancelled and rearranged.

In three of the six meetings observed, issues being presented were seen as being funny and humorous but this did not stop them from continuing their discussions. On one occasion a CPN presenting a case said that the patient who worked as a topless model thrust some pictures of herself at him. There was laughter as some of the staff teased him saying that they were sure that he did not want to see them and anyway what did he think she was up to, he smiled in embarrassment and said that they were professionally taken photos and he had been forced to feign interest and look at them as it seemed to mean something to her, there was more condescending laughter as he hurriedly

continued his presentation about her benefits and her previous allegations of being harassed and stalked by various people. The manager and consultant intervened as usual with their memories of this patient and asked for specific information and so the discussion had continued.

On another occasion, Dr Y was wondering why one patient had been referred now, as his delusions were not new – this patient believed that he was Rasputin – the world's greatest lover because he had a beard – he has also been buying a lot of things that he doesn't actually use from catalogues and he had not shown any improvement on Risperidone – perhaps he could be tried on something else. There had been some twitterings from staff and grins all around at the patient's delusions.

On the third occasion, the SPR presented the case of a man who believed that he had Asperger's syndrome and was struggling to overcome the effects of this disorder by taking alcohol and drugs. The team burst out laughing when it was mentioned that he was holding a job with Customer Services at British Rail – with comments such as , *'typical'*, *'now you know why'* and *'that explains it all'*.

Each time the laughter was very contained and specific and the presenting staff just grinned and carried on with their presentation without stopping to extend the innuendos and the meeting was able to deal with the concerns.

Visit Observations

I accompanied individual staff during a visit to their patients. Staff met with patients for a wide range of reasons, including supervising their health and well-being, monitoring their medication, formal therapy such as CBT, discussing an urgent issue, helping with gaining suitable housing and considering applications for appropriate benefits. Though 8 of the staff had said that they had discussed my visit with their patients before confirming it with me, all of them again sought the patient's agreement at the time of the visits. The locations for these 10 observations were; a hospital acute ward, the outpatient clinic, the office base, staffed accommodation and independent flats of the patients. Three out of

the 10 visits were to more than one patient so that there were actually 13 patient contacts observed and a further two patients were not available at the time of the visit. At the observation of an out-patient clinic with the consultant, two patients agreed to my presence and two did not. One of the 13 patients observed was being visited as she had been refusing to take her medication so that staff had been asked to try and see if she would take it on this occasion but she did not engage at all. Apart from these refusals, on 6 other occasions staff had to rearrange the visits as patients either did not attend or called at the last moment to say that they were unable to keep the appointment. A small number of these missed appointments may have been a reaction to my planned presence but there is statistical evidence that most CMHT patients have between 25% and 40% DNA rates.

Staff Role

The CMHT is the gateway to specialist mental health services for people who are unable to be managed by primary health care, either because their illness is too severe or because the effects of their illness requires a multidisciplinary approach. On rare occasions patients in a crisis may be admitted to hospital directly, bypassing the CMHT. Once in the hospital, they are referred to their local CMHT or, if they are homeless, to a CMHT on a rotational basis. On being accepted by the team, staff are allocated to coordinate the care that they need to remain well in the community. Staff keep in touch with patients either by seeing them in their office or visiting them several times in between CPA reviews. Patients are kept on the team's caseload only if they continue to need regular contact, either because they need the direct services of the team or they require the team's help to access and retain other resources in the community. However, the significance of these relationships with staff is evident from the fact that they are seen as a 'critical friend' who can be sought out to give advice on making vital decisions as in the excerpt below:

Dr Y asked her how she was and Edwina said that she was fine and that she had been following this timetable she had set for herself but there were still some gaps

allowing boredom and thoughts of worthlessness to creep in – she had to find other things to do – Dr Y asked what kind of things and she said that between cooking and eating when she was waiting for her husband, she found the time empty and boring. She talked a bit more about this feeling of boredom even if she had a very short gap in her routine, before saying that her biggest problem was to decide whether she needed an attorney – Edwina had been thinking of giving power of attorney to someone she could trust so that they could look after her money should she lose her faculties – and wondered whether her accountant should be appointed – she had talked to him and he had also thought it was a very good idea. He had told her that he too had put something in place for himself – this seemed to have convinced her that she should do it anyway - she dwelled on why he would make a good attorney until Dr Y asked about Edward her husband – and Edwina said that at present he took care of all her affairs but she did not feel sure whether to make him her attorney, not because she had any doubts about him but because it might be better – didn't people have outsiders as attorneys? Dr Y pointed out that at the moment Edward was doing fine and that she may never need it as most people were able to deal with their affairs all their lives so she might actually never need one. She thought about this for a bit and felt that though she was not very up-to-date with everything as Edward took total care of her affairs and she trusted him, she would also be able to do it herself should she ever need to.

During these contacts, staff focused on practical issues that were important to patients, whether it is going for a coffee at the local café or clearing out the rubbish in their flats. Mental illness is a small part of their lives which nevertheless affects every aspect of it, so a variety of help is available to address their problems to enable patients to live in the community. During these observations, each of the 13 patients visited seemed to present different sets of problems, whether it was open conflict with a neighbour, refusing to take depot medication, demanding support to get a prescription for a particular drug from the GP, assistance to claim benefits, dealing with difficult demands from partners, plans to overcome their negative symptoms, struggling to accept signs of relapse and so on. Many of the visits also set up meetings with the consultant or CPA reviews. 6 patients

had issues with their housing, wanting to move on from their current accommodation whether it was an independent flat or supported accommodation. An integral role of staff is advocating on behalf of their patients, as in the excerpt below:

John the project worker sat down and shut the door - there was a stale smell from the corridor- he told James (CPN) that he was planning to move Winston to the project down the road which had slightly less staffing as his responsible local authority were dragging their feet about moving him on. James said that he had been following it up with the care manager and both of them expressed shock at the emails that they had been receiving from her, where she had been complaining about her stress due to the large caseload. They discussed that all of us are under a great deal of pressure but for her to declare that in an open email was surprising – she should really take it up with her manager – it followed that James had been trying for many months to get them to take responsibility for Winston – originally he had been in hospital for a long time and, in order to create a bed space, he had been moved into this project which at that point was a residential home – when the funding for this project had changed, it had been agreed for him to stay on – until he was found local accommodation by his local authority but this had not been actioned as there had been so many changes of staff in that particular service. James asked for some more details about the project down the road and was very unhappy that Winston was being moved yet again into a similar project in the same locality and will have to wait to move back into his originating borough - so many moves were not good for Winston – John seemed apologetic as he said that he had been instructed to create spaces here by moving Winston out though he could see James’s point about too much disruption for the patient. James said that he would write to everyone and get his managers involved as he did not at all agree with this plan for Winston. The meeting ended with James still annoyed and John apologetic as he said that he needed to do this as part of his hand-over to the new manager.

In 9 out of the 10 observations, there were indications that the team liaised closely with staff from a number of other agencies – the only visit where this was absent was one

where staff spent the whole meeting completing a benefits application form. Another issue that constantly came up was the demand on the available resources and the need for staff to put up a fight on behalf of their patients to access these.

Patient Characteristics

The team has a caseload of about 250 patients who are allocated care coordinators. The consultant has a further 200 patients that he sees in the outpatient clinics along with the other junior medical staff. Each non-medical staff care-coordinates a caseload of between 18 - 23 patients. Some of these clients are quite damaged by their illnesses and need to have 24-hour staff support to live in the community and, even then, one wondered about the quality of their lives. Of the seven patients seen in accommodation where they lived in the community, at least three of them were very ill-kempt and had not washed for several days. They lived in accommodation that smelt strongly of stale sweat and faeces and their beds were soiled and did not have sheets on them. We saw one patient sitting on her bed with her head in her hands when we were let in by the support worker as she had refused to open the door. The staff with me tried to get her to take her injection but all she kept repeating was that she would take it next week. I was told that she had said the same thing to a colleague the week before and the week before that. Staff on site were asked to monitor her food intake as she had become withdrawn and could go for weeks like this and then snap out of it and comply with medication and do other activities to care for herself.

However, a number of the patients seen during these visits were functioning fairly adequately in the community, despite frank evidence of being affected by mental illness or a pathological dependence on illicit drugs.

Sally said that she had been quite busy with her house hunting – that she had been bidding and had gone and seen a couple of houses she really liked but she did not have enough points to be able to get the property. Francis (SW) said that one of his colleagues had a client who lived in a large three storied house - her father had recently gone into hospital and had died and now she wanted to move into a two

bedroom flat as she did not need such a large house anymore – the house was old and the Council had done nothing to it but it was large and had a garden – he said that he had not seen it himself but he understood it to have a lot of room – he went on to describe what it might be like saying that though it was identified by the ‘Partners’ for renovations – this was not likely to happen in the near future so there would be a lot of work needed. Sally said that she knew about the Council’s ‘Partners’ programme as she had personally supervised their workers to do up her current flat to a very high standard but her brothers were builders so they would do any immediate work for her as long as there was space and a garden. She asked him if he had heard from the Children’s Team – when he said that he had not heard anything, she said that she had had negative results a couple of times recently. She had really been good and stayed in most days during the week but had gone out on Saturday and then lost it – she said that she found it very difficult to restrain herself when she went out whether she was out clubbing or just visiting friends in their homes – she could not resist the stuff they took and all the people she knew were like that so it was very difficult to not join them. Francis asked her if she went to the Drug Centre and she said that she had missed one appointment with them as her worker had not been there but that she was going there quite regularly. Francis asked her if they helped her think about how she might decline stuff when she was with friends who took drugs and how she could still go out without having to take drugs – and she said that she will have to concentrate on that a bit more but she found it extremely difficult and it was such a bother that even if she took something on a Saturday night it showed up on Wednesday in her blood test. She said that she needed to find other things to do. Francis agreed saying that it was bad enough having to give up something but then one had to find something else to replace it and he understood that was really tough.

This level of empathy with the patients regarding difficulties with their symptoms was not unusual, however it was also evident that staff were able to switch off from identifying with the patient’s state when there was business such as completing a form or ensuring that they were taking medication or gathering evidence of harassment in order to get

alternate housing. These observations revealed that staff know their patients very well and have an easy relationship with them on the whole. The normally easy relationship built up by being available to get involved in several aspects of the patients' lives includes an understanding of and tolerance of their own trepidation as they work within the patients' expectations and reactions, as seen in this comment by another staff (psychologist) following a meeting with a patient:

After she had gone, Debi commented that Andrea had appeared very well and that she had also presented better than Debi had ever seen her since taking over her care coordination three years ago. Andrea usually came in very angry and would throw up all her problems as if Debi was not good enough – she felt let-down constantly – she had been homeless when she had been referred to the team years ago. She felt abandoned and felt that everyone owed it to her to make it perfect for her - she was very critical of the world and she forcefully transferred this on to Debi each time they met – Debi was uneasy about meeting with her because it was so difficult to break into her cycle of blame and anger – but this time she had been very good – much more settled and less accusing – less 'difficult' – it was good to see her get on with life.

Countertransference

My own observation notes about the above meeting with Debi ended with the following paragraph:

I am amazed as I write this observation: I did not remember my own discomfort during the meeting until I wrote the above paragraph about Debi's unease. About twenty minutes into the interview I had experienced an urgent urge to cough – my throat was scratchy but I could not bring myself to cough or clear my throat – for fear of disturbing Andrea – I had sat very still trying to listen to them and when I could not bear it anymore – I gently bent down and got a mint from my bag – I also realised that soon after this – I had been feeling so drowsy that I had difficulty keeping track of the conversation – my mind kept straying with thoughts about my work – about how I was

going to write this up and I had to make an enormous amount of effort to keep alert and concentrate on the interview.

I was acutely aware of my own identification with staff as they went about their day-to-day business – responding to the demands that patients made on them and the unease that sometimes this evoked, for instance in the above passage, Debi's discomfort and desire to cut off seemed to be projected on to me. However, sometimes my identification seemed to be entirely with the patients as in the passage below:

Maureen (SW) asked him how he was and he said alright – she asked about his sleep – was he eating alright – he grinned and said 'can't complain' – he repeated 'can't complain' for several questions as they were completing the (benefits) form and even when Maureen wanted some specific information – he would grin and say 'can't complain', e.g. when she asked him whether he was responsible for any minors or how far he could walk without getting breathless. Once in a while he would say 'can't say porkies' or some other cockney phrase that just did not seem a right answer for the question being asked. Throughout he was elated as he continued to use language that did not seem normal to him – all-in-all it was an amusing experience for me and I found it difficult not to grin or burst out laughing when he would happily turn to me and (mis)use a phrase – however, all this seemed to be lost on Maureen who ignored both his mood and his off-the-mark answers. She was seriously going through the form and asking him for information that he was not providing. When she came across questions that needed comprehensive answering, she said that she would get the information from the file and from his income support form: he seemed happy enough with that.

As I presented the above observation to the seminar group, I could not help laughing uncontrollably and suddenly realised that in stark contrast to Maureen's focus on the form as a defence against the mania and engaging with it, I had totally identified with the patient's manic state so that I had taken in very little during this observation which had caused enormous problems with remembering subsequently when I was writing up the observation.

Two of the patients in the community were too apathetic to acknowledge my presence some of the others were preoccupied but nodded in my direction when introduced and when I thanked them at the end of the visit. There were a number of patients who were totally aware of me and would turn to me in the course of their conversation with staff, such as the excerpt below:

As Edwina took on board this information that she might not deteriorate or become totally dependent on others, there was a silence. She looked at me and smiled and asked whether I was from Mauritius – I said no – but before I could say anything else she said that people from Mauritius looked just like me – and then she lost interest in me and turned to Dr Y to say that it was such a nice day – she had been enjoying the sun these past few days.

Though as a researcher I had taken a stance that I would not initiate any conversation with the patients during these observations, responding to their queries with simple truthfulness seemed to satisfy their curiosity. It was interesting to note my own reactions to the patients as in the excerpt below where the visit was to a patient who was very dishevelled and his accommodation was in a dire state with an unbearable smell:

Jack (CPN) asked him how he spent time and, pointing to his hi-fi systems, Gerry said that he normally liked to listen to music but sometimes he went out for a walk but that was a bit lonely. I wondered if he had family or friends and whether Jack was involved in improving his social life. There was a silence and I realised that though he responded to Jack, Gerry had not initiated any of the questions – was he resigned or not bothered – it took me a while to realise the apathy in Gerry – there was no eye-contact with Jack, although he appeared to be responding to him. He had not even looked towards me when Jack introduced me, nor did he look at me while Jack asked me to confirm a point he was making - he did not seem annoyed – just not bothered. This seemed to be Gerry's way of keeping people away from him – excluding himself from society. And yet this did not seem to warrant any action or even comment from Jack, leaving me wondering about the lack of focus on community integration for patients. Looking around the room I wondered how many of the things there Gerry

valued and would miss if they were to be removed – and yet the panic in his eyes had been very real when Jack had mentioned readmission to the hospital if he did not take his medication – I wondered what it was about the hospital that frightened him so. Returning from these thoughts, I realised that the dirt and smell in the room did not bother me anymore – so much so that as we left the room and re-entered the corridor the smell there hit me so hard again that I was tempted to put my fingers to my nose.

Staff Interviews

In addition to the staff who took part in the observations, the manager was also interviewed, making a total of 11 interviews. All interviews were done following visit observations – some immediately after. Talking about the generalised nature of their role within this team, a number of them described it like this:

My work involves care coordinating a caseload which means that I have a particular number of cases allocated to me and I am responsible to liaise with other services like housing, DSS, daycentres, you know, all things that affect a person - if they are having problems with their income, I liaise with the DSS, help them do their application forms; if it's a housing issue, I liaise with housing and also to make sure I promote mental health by referring the clients, maybe to day centres, colleges or anywhere else to promote social inclusion and if they are relapsing to make sure that they attend or refer them to the crisis team or work with them - maybe liaise with the GP, with the consultant,- have meetings with everyone involved – more contacts - in terms of contact with the family and try as much as possible to avoid an admission. But at times they end up being admitted and then when, they are in hospital, I still continue to visit them and if there are any needs, I attend to them like taking them home to get their things or if a client is detained in hospital and if they want to appeal against their section, my role will be to do a tribunal report, either supporting that they be discharged from the section or supporting that they remain on a section until they

are much better, and my other role is to engage – liaise with the family or friends and other carers with regards to the care of the clients.

Staff said that though they came from different professional backgrounds, they took a holistic view as care coordinators of patients who were on the CPA register. Staff acknowledged that, unlike many specialist teams, CMHTs hold comprehensive responsibilities for even minor aspects of patient care and need to look at things in that contextual framework. They made more references to managing pooled budgets from health and social services and consequently having to enter data for the two masters and prepare for rigorous clinical governance and multiple audits. This preoccupation with two bosses and continuing difficulties in the integration of health and social care is surprising as CMHTs were the first teams that were jointly set up by the two statutory authorities of health and social services; it also seems to be dysfunctional by reducing the time staff spent in face-to-face contacts with their clients.

Staff Qualities

'Working with people means everyday it is different people and each time it is different with the same people'

Many of the interviewees talked about the variety offered by working on the frontline of specialist mental health services. At least four of the interviewees said that the diversity of clients within a CMHT makes it extremely interesting work however this meant they got inundated with referrals:

'You trade off diversity for the team being a bit of a dumping ground for all and sundry sometimes'

Staff said that in supporting people and maximising their potential through rehabilitation and teaching of day-to-day skills that some of the patients had lost, they needed to develop beyond the narrow professional boundaries - *'be a social worker as much as a nurse'* and strive to be at the cutting edge of work in this area simply because the work is not narrowly defined by the patient's psychiatric diagnosis.

This team is different from the other two teams that took part in this research, in that a majority of staff were working full-time in it and did not seem to be pursuing personal hobbies or courses for further professional development. Though their basic qualifications seemed to suffice in order to carry out the tasks expected within this team, a couple of staff had independently taken up further studies. The manager emphasized that in addition to their professional qualifications, staff needed to have an understanding of developmental issues – about the influence of early experiences on later life.

I value a sense of humour as well – the work can be stressful and difficult and we work with people who've had very difficult and distressing backgrounds – so if you have a sense of humour about it – that helps and if people can remain calm – in this work where there is risk – and some of the clients may have committed dreadful offences in the past or you read their risk history and you just want to run away from it – its about keeping it in perspective and erm . . . remaining calm about it – not panicking when you see what the risk assessment says – and building relationships with the client -- you look for sensitivity, someone who is empathetic , understanding of e.g. child development and a lot of what goes on in childhood – attachment, bonding, deprivation – they really do affect your development , personality and mental health later on.

This team had the widest range of staff ages and collection of past experiences. Commenting on the sad demise of the therapeutic role of the mental health practitioner one experienced staff (SW) talked about the lack of opportunities for counselling and other systematic therapeutic interventions in modern services and its obsession with mountains of paperwork, endless in-putting of data and other forms of justification and the fast changing service environment with even faster changing 'buzz-words'.

Stressors and Supports

Staff acknowledged that one of the most difficult aspects of work in this team was being the first to assess and work with the mental illness of people despite the fact that GPs might have identified it to begin with. The unending deluge of referrals puts constraints

on the time and resources available to do therapeutic work with patients. The demands on data entry, paperwork and other bureaucratic procedures was seen as further divesting time from direct face-to-face work with patients. Some of the staff were unhappy that lack of adequate resources meant assessments were not truly needs-led but were restricted by what resources were available - it was difficult to get the whole picture – to understand what was going on in patient’s personal and social life or what their physical and psychological needs were. Further, in coordinating the package of care being offered to patients, staff had to deal with non-statutory services or organisations who were also involved in other aspects of that care. In having to form relationships with people who might have had different agendas – different ideas about what they think was right for the client in their narrower view, rather than the whole picture - staff acknowledged the difficulties of developing effective communication strategies, especially outside the team. They expressed a need for containing these anxieties, while coping with an environment of ever changing government and Trust policies and:

‘acknowledging what’s going on - learning new terms and jargon, but thinking in a couple of years its probably going to be called something else and becoming comfortable with that’.

As political demands for a business model of an organisation with performance targets force the team to increasingly focus on the patients with more complex needs, it is not unusual for these patients to have forensic backgrounds and aggressive behaviours. Holding individual responsibility for caseloads within the community did not allow for sharing the stress of dealing with difficult experiences. Violence in the form of verbal abuse and physical assaults seemed common place. In the few weeks of collecting data in this team, I was told about two occasions when patients became so distraught that they had jumped over the dividing barrier in the reception and attacked the staff member who was trying to calm them down. Though staff were offered intensive support from the manager, there was a routine-ness in the way these incidents were dealt with. Having to hold on to this emotionally taxing work during the day meant that staff felt they were less

emotionally available both for their own personal needs and to friends who were experiencing ordinary distresses of life.

Two of the eleven interviewees said that, though there were increased risks and reduced immediate support in the community, staff were better valued and respected by colleagues compared to on the wards. Fortnightly supervisions, in addition to the short daily meetings and the weekly clinical meetings, were seen as being very supportive in getting advice for making decisions, both about care and for referring on inappropriate patients:

. . . there are a lot of good things about the team – assessing clients, not taking them on if they don't need (specialist care) CMHT – which is really important because there's no point in stigmatising them. We are quite good at moving them through and discharging them so that we don't have absurdly high caseload numbers. Those sorts of practice and system issues are dealt with well in this team. I think there is a good deal between the consultant and us – we do have a conversation – if you've got a doctor who's unapproachable – it makes our job harder after doing 90% of the job. They just sign on the dotted line. They need to have some faith in us.

The availability of both the manager and the consultant for advice and support was appreciated as was the communication systems, including email facilities to report events immediately within the team, which were seen as significant in doing this work.

Risks and Audits

A number of staff talked about the risks inherent in this style of working. 7 out of the 11 interviews elicited trepidation about serious untoward incidents involving patients, staff and the community in general. This was dwelt upon at the same time as discussing the need to take measured risks and put adequate systems in place. The consultant said:

Well, I think of risk in the obvious physical sense – in terms of emotional burnout and risk to the patient and the public – whether the patient self-harms and neglects or is a physical risk to others – for e.g. a personality disordered patient – who frequently self-

cuts, is in crisis – admitting to hospital isn't always the best solution and you have to tolerate that – yes, we have a different treatment plan to try and change their behaviour – it may involve them self-harming or an impulsive unforeseen overdose that kills them – you've got to hold your nerve and work with that and not always admit to hospital.

Talking about the systems in place to address these identified risks, the manager said:

We do have systems in place – the lone-working policy - about visiting patients alone such as having their mobile phones on them and checking in and out – that if a patient is known to be violent at times then visits need to be done in 2s or the patient comes to the office, and that as much information as possible is gathered before doing a domestic visit – but if there are gaps in this information, there is no rigid policy about doing the visit in 2s. There is a struggle to achieve the balance between rigid policies and making optimum use of limited resources to address waiting lists and have reasonable frequency of visits to patients. We have weighed up these issues – the need to ensure that difficult patients are given time for reflection and that staff have time to reflect on difficulties with patients - in the past we had access to an external psychotherapist to run a support group, but it was not used very well by staff. We also have a slot within the team meeting to discuss these things but nobody uses it - so that the obligation to provide support falls almost entirely on supervisors and the line managers.

The manager kept a clear view of referrals and assessments in addition to doing the 'balance scorecard' every quarter, which consists of looking at all the contacts recorded on the electronic client register. This included looking at statistics, such as whether the 7 day follow ups of patients discharged from hospital were taking place, waiting times for new referrals initial assessments and whether all new patients allocated in the last six months had risk assessments. The other audit carried out monthly by the Trust clinical governance department was of the CPA – checking all the forms to see if the care plans reflect the needs and if the tick boxes have been completed e.g. if there are children, if the diagnosis is confirmed, if there is a crisis plan, a date for the next CPA review and

whether the forms are signed. Within the team itself, the managers carry out regular file audits to ensure that they contain all the information and are kept up to date. The team is measured on certain targets like having six-monthly CPA reviews, whether there are regular contacts to reflect the patients' care plans, how long patients stay on the caseload and how many serious incidents have occurred over a period. These measures are mere overviews and rely on the accuracy of statistics recorded by staff. Most senior staff believed that there was at least 30% of the team who did not believe in these systems and the effectiveness of prioritising these recording measures. They also expressed the opinion that clinical governance, as it was operated, was not able to give a true picture of the team's success or the quality of work.

Inferences and Organisational themes

In trying to understand how staff function within these teams it was felt necessary to consider both individual staff and the team as a whole. As Gould (2004) puts it:

'The systems psychodynamic framework is specifically intended to convey the notion that the observable and structural features of an organisation continually interact with its members at all levels, in a manner that stimulates particular patterns of individual and group dynamic processes.' (p 40)

The Team as a Social System

Mental health services are set up as specialist services to supplement primary health care. There is an expectation that all people are registered with a local GP clinic with whom they maintain regular contact. Being the first port of call for any health problem, the local GP who knows the person is then able to refer them on to the secondary services, either for consultation or further treatment. The first stage within secondary care in mental health is the community mental health team. There are other teams, such as home treatment teams and the out-of-hours services which may also be used as the initial referral for the patient depending on their situation at the point of referral. However, the majority of cases and any patients routinely needing specialist mental health care are

referred to the CMHT, both by general practitioners and other relevant agencies, such as housing services within the area.

The motives for referring patients to this team are threefold: first of all for advice regarding their behaviour or treatment; secondly for accessing supplementary services such as housing, therapy groups, day centres, etc.; and finally for ongoing care and support via the care programme approach. Here a comprehensive assessment of their mental illness and the resulting needs is completed, following which some patients are held in the team for ongoing and longer term care and others are referred back to their general practitioners with advice, whilst a small number are referred on for more intensive short-term care from tertiary services, such as in-patient wards or the Crisis and Home Treatment Teams in the community. The Crisis Team is involved for a short-term, both to prevent hospitalisation and to help patients settle down in the community before discharging them. Those patients who disengage but continue to be unwell and are repeatedly admitted to hospital are referred to the AOT. First time referrals of patients in their teens or twenties are referred on to the Early Intervention Team. Despite all these alternatives, CMHTs have the largest referrals and the most inclusive entry criteria. As described in Chapter 1, CMHTs were set up to fulfil the statutory obligations of caring for the mentally ill in the community and so they are audited to the greatest extent by both their funding agencies. However, having been set up when there was little knowledge of what was needed from and by such services, they have the least structured support and do not have the same 'exciting' status as the newer 'evidence based' teams.

Primary Task

In understanding the direction and function of this team, it is important to note that its two masters have very different sets of statutory responsibilities towards the mentally ill patients in the community. Set up as a multidisciplinary team with staff coming from several different philosophies of care and having to achieve two distinct sets of performance data, the team struggles to achieve uniformity in its function and aims. Nevertheless, it is set up to fulfil the primary objective of fulfilling their joint legal obligation

for providing specialist care to people whose mental illness is too severe to be managed within primary health care. Its Normative Primary Task, which is assigned by the two funding agencies, is to care for the severely mentally ill patients in the community by co-ordinating their care and also by offering consultation and advice to their GPs. The Existential Task, that the staff in the team believe they are carrying out, is to improve the quality of patients' lives through short-term interventions when patients are in a mental health crisis. However, the Phenomenal Task, which is inferred from the behaviour of staff as they go about their work, is that they focus on preventing patients from harming themselves or others while continuing to live in the community, avoiding hospitalisation. The pull in these different directions is experienced by staff in meeting their performance targets of implementing disparate objectives, whilst adopting homogenous roles, and puts unrealistic expectations on them. The staff's preoccupation with short-term tasks, managements' preoccupations with risk and the employing authorities' preoccupation with audits and measurements make for an untenable work environment. Despite all these adversarial circumstances, this team continues to demonstrate positive indicators of health such as low staff turnover, vacancies and sickness levels.

Basic Assumptions

The team has a strict hierarchy, with the consultant, the managers and the seniors in gradually reducing positions of responsibility for the work of the team. In its day-to-day operation, the team is apparently engaged in the psychosocial care of patients by involving them to prioritise their needs, thus creating a dangerous dependency on staff. There is a need within staff to inform the consultant about their experiences, as if it is intolerable to hold on to the responsibilities of their work and that by communicating it to the consultant they are rid of it. The consultant himself is aware of this dependency, although there is no effective structure to divert it, but individual staff function adequately and the team is able to focus on efficiently addressing the needs of its patients and referring them on, instead of dwindling into basic assumption dependency. By keeping the teams' criteria under regular review and jointly encouraging staff to adhere rigorously to these criteria and review their own work with patients, the manager and consultant

have kept caseloads at manageable levels in an attempt to reduce the effects of burn-out on staff. The team continue to have very high expectations from these two senior and long-serving members of management that could almost be seen as verging on Basic Assumption Pairing as discussed in Chapter 1. However, the team continues to achieve its performance targets and accomplish reasonable success in its audits, thus fulfilling its obligations to its patients, its employers and to some extent, to its staff. Perhaps another reason for not being totally preoccupied with the basic assumptions mentality, to the exclusion of any meaningful activity, is the fact that staff in this team live and work as individual islands of strength with little encouragement or opportunity for intra-team bonding.

Social Defences

Analysis of the data revealed ways in which staff dealt with the primitive anxieties evoked by the constant exposure to patients whose disturbance disrupts their social functioning, disabling them from managing even very ordinary aspects of their day-to-day activities. Of the three teams researched, this team has the greatest potential for identification with their patients because the kind of patient issues they are expected to get involved with is wider than just severe mental illness, so that their own life experiences and life styles are the least different from those of their patients.

It is difficult to gauge the patients' vulnerability or the severity of their day-to-day living problems by just judging their appearance and presentation. This facilitates the unconscious identification of staff with them. Personal and professional boundaries are more difficult to hold on to as staff get more and more involved with the patient's issues, so that it is not unusual for them to involuntarily utter, "*Oh, she is the same age as me*", or, "*I could easily be his father*". This level of identification with their patients evokes an empathy more easily explained as, '*There, but for the grace of God, go I*', evoking an intolerable amount of severe anxiety.

Humour in this team is often used to deflect the tension aroused by the issues being presented. Laughter which was heartfelt was often the response for any situation which

could be construed as having the slightest amount of jest in it revealing a keen attention to presenting details. However, this did not detract them from attending to the business of patient care. During the meetings, as staff continued to present mundane difficulties of patients, the drone of their voices often made me drowsy or distracted. More than once, I found myself looking at the colourful flowers in the adjoining garden, only to be jolted back to the team by a joke made by staff who had picked up on some vaguely funny aspect of a point being made by the presenter.

A number of quantitative studies, such as Evans et al (2006), have shown that staff in CMHTs have the greatest potential for burn-out and that social workers are particularly vulnerable. Social workers were found to be the least supported and most susceptible because of their additional responsibility for 'public protection' in their role as ASWs and because they are based in a health setting, where health-care staff are a majority and where they have to deal with problems overwhelmingly focussed on illness and whilst being dependent on senior health staff like the consultant.

Senior staff in this team attribute the cause of burnout to the anxiety evoked by the onslaught of referrals and large caseloads, in addition to the real and imagined risks that staff face as they go about their duties alone in the community. By strictly monitoring new referrals and reviewing existing caseloads, managers are constantly striving to reduce the stress on staff. Detailed case-reviews, supervision, the daily morning meetings, the weekly clinical meetings, making available space for staff to discuss their anxieties and procedures such as the lone-working policy, are the other structures put in place to counter the negative longer term effects of this anxiety on staff.

Denial, splitting, projections and projective identification

As the dumping ground of the specialist mental health services, this team deals with all kinds of patients with a wide range of issues, from the totally mundane to the most interesting. Routine issues that people would normally be expected to deal with unaided were often brought to the team as patients had lost the ability to independently sustain living in the community. Being used to automatically getting involved in a wide range of

issues, staff are in denial of the amount of dumping of emotionally charged material that happens from the patients. This is evident from their lack of take-up of both the support group facilitated by an external consultant and the time slot in the team meetings made available by the managers of this team to discuss feelings. The resulting burnout is also a symptom of the dumping by both the primary and more specialised secondary mental health services of all the difficult cases that are unwieldy with no clear-cut diagnoses or manageable treatment solutions. In turn, when faced with the unreal experiences of seriously psychotic patients, staff looked at ways of getting rid of them by finding other services to refer them on to, thus splitting themselves away from those services that were viewed as being especially set up to deal with SMI.

Holding independent caseloads and working alone in the community are significant factors in that, apart from supervision and the occasional discussion in clinical team meetings, the patient's situation and the resulting staff experiences are not shared with colleagues in any substantial way. There is little communication between staff beyond colleagues at the next desk – the isolation being so stark that staff seemed unreachable so that it was only towards the end of my visits that they began to even greet me. In addition, the almost ordinariness of some of the problems that patients present makes it difficult to become aware of the projections received from them and to differentiate these from the day-to-day personal issues of staff themselves. For those staff who are aware of the effects of these projections and projective identifications, the anxiety provoked is intolerable and leads to a preoccupation with stringent boundaries between work and personal lives which are limiting, to the extent that they are ineffective with patients and unhelpful to colleagues. However, those staff who are unable to reflect and separate personal and patient issues just react to these anxieties. Constantly reacting, without the time or means to reflect and understand the effects of responding at an emotional level to work demands or sharing them with work colleagues, could prove potentially fatal in the longer term.

Conclusion

As the gateway to specialist mental health services, this team is reasonably successful in addressing political agendas such as 'keeping mentally illness out of sight of society' while at the same time attempting to ensure the social inclusion of clients. Though it took longer and more effort to get staff to participate in this research, even after starting my data collection in this team, in the end a large number of staff did take part. Whilst maximising the use of staff skills through generic mental health work, this team attempts to address the needs of its community by working beyond the narrow definition of severe mental illness. However this may sometimes be over inclusive and even misdirected – for instance their enthusiasm to respond holistically to patients may unnecessarily complicate the initial request of the client or worse still, totally miss it, for instance in the case of the 23 yr old man presented above, he was referred for psychological help – CBT, but the team was looking at many other aspects of his life and did not make any decisions or arrangements for CBT or any psychological input. Another issue that was totally missed was his occupation; training or employment. Despite these short-comings, there was evidence that the team was using the wide range of resources available in the community to enhance its work with patients.

The intensive audits seemingly carried out regarding every aspect of its work do not particularly measure success, especially in terms of outcomes for patients or job-satisfaction for staff. Senior staff are aware of the potential for burnout in this kind of work and are striving to put organisational structures in place to address it to some extent. However, more effort towards enhancing the independent skills of staff and putting in place structures to particularly target their anxieties by identifying and addressing them would enable the team to work better.

Chapter 6:

Comparison of Themes and Discussions

Introduction

Following the description, analyses and interpretation of the data in the last three chapters, an attempt is made here to compare the findings from the three teams. All the three teams are jointly set up with funding from health and social services; they consist of staff from different disciplines doing highly specialised work and are subject to a number of statutory demands placed on them such as implementing the MHA and the NSF for MH. The comparison will start with the location of the three participating teams within the larger system of mental health services in the UK comprising of primary, secondary and tertiary care, with details of the Referral Pathways followed by Care Pathways for clients.

This will be followed by looking at four areas suggested by Ovretveit (2001) in understanding how mental health services in the community have evolved over the last twenty years: Membership: Arising from a loose network of practitioners into a formal, organised team and drawing boundaries and clarifying its purpose; Accountability: where team members are assigned to a group which is collectively accountable for using the group's resources to provide a distinct service to a defined population; Management: While staff are primarily employed by health and social services, teams have evolved different management styles embracing core staff management which allows appropriate autonomy and supervision for practitioners from different professions; Pathway and decision making: The team consists of a clearly defined group of staff with a centralised decision-making process and one general pathway for clients including a single point of entry, followed by a comprehensive assessment and a care-plan which is regularly reviewed, and move-on from the team according to an agreed policy.

Some core data from the team-questionnaires and the team-feedback sessions which was not included in the previous three chapters will be included here. Some information

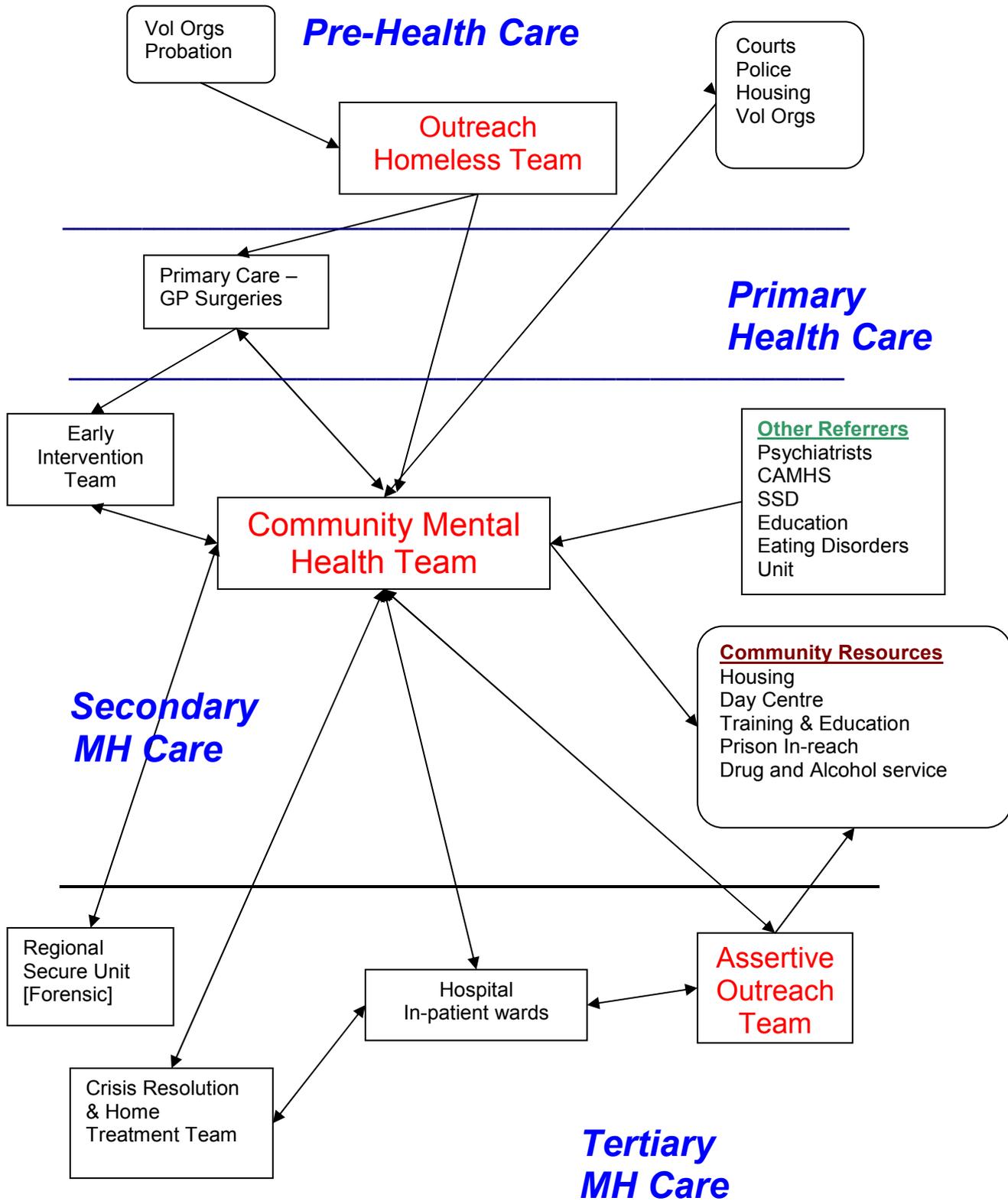
that was additionally sought for the purposes of understanding certain issues such as performance indicators and other regulatory processes is also included in the section below on Accountability. In addition there will be a comparison of themes such as the nature of clients, the nature of the teams, the systems and structures within them and the characteristics of staff themselves which enables them to work with the clients and achieve the objectives of these teams. Further comparison of the inferences drawn in each of the group will be included and a brief conclusion drawn.

The systems context

It was found that, quite accidentally the first two assertive outreach teams that took part were at the opposite ends of the referral pathways for clients. In order to achieve a more balanced sample of staff, it was decided to include a third team which is a better representative of the majority of teams engaged in addressing the mental health needs of people in the community.

Chart 6-1 [below] shows the location of these teams at very different positions within the referral pathways within statutory mental health services:

Chart 6-1 Organisation of Mental Health Services



It is traditionally expected that everyone in the UK is allocated to a general practitioner, who, as gatekeepers to health care, form the Primary Health Care services. Over the last 40 years there have been several researchers such as Shepherd, Bennett, Bebbington and Strathdee, who have looked at the interface between primary and secondary health care. Goldberg et al (2001) found that up to a 10th of all patients seen by GPs have mental health issues. In an earlier paper Tantum and Goldberg (1991) had classified the kind of patients who are seen by a GP pointing out that on an average only about a quarter of these cases identified by the GPs are referred on to specialist mental health care. In addition, several studies including those published by WHO, claim that a large proportion of people who experience an episode of mental illness get better without ever being identified by their GPs.

Care Pathways for people with Mental Illness

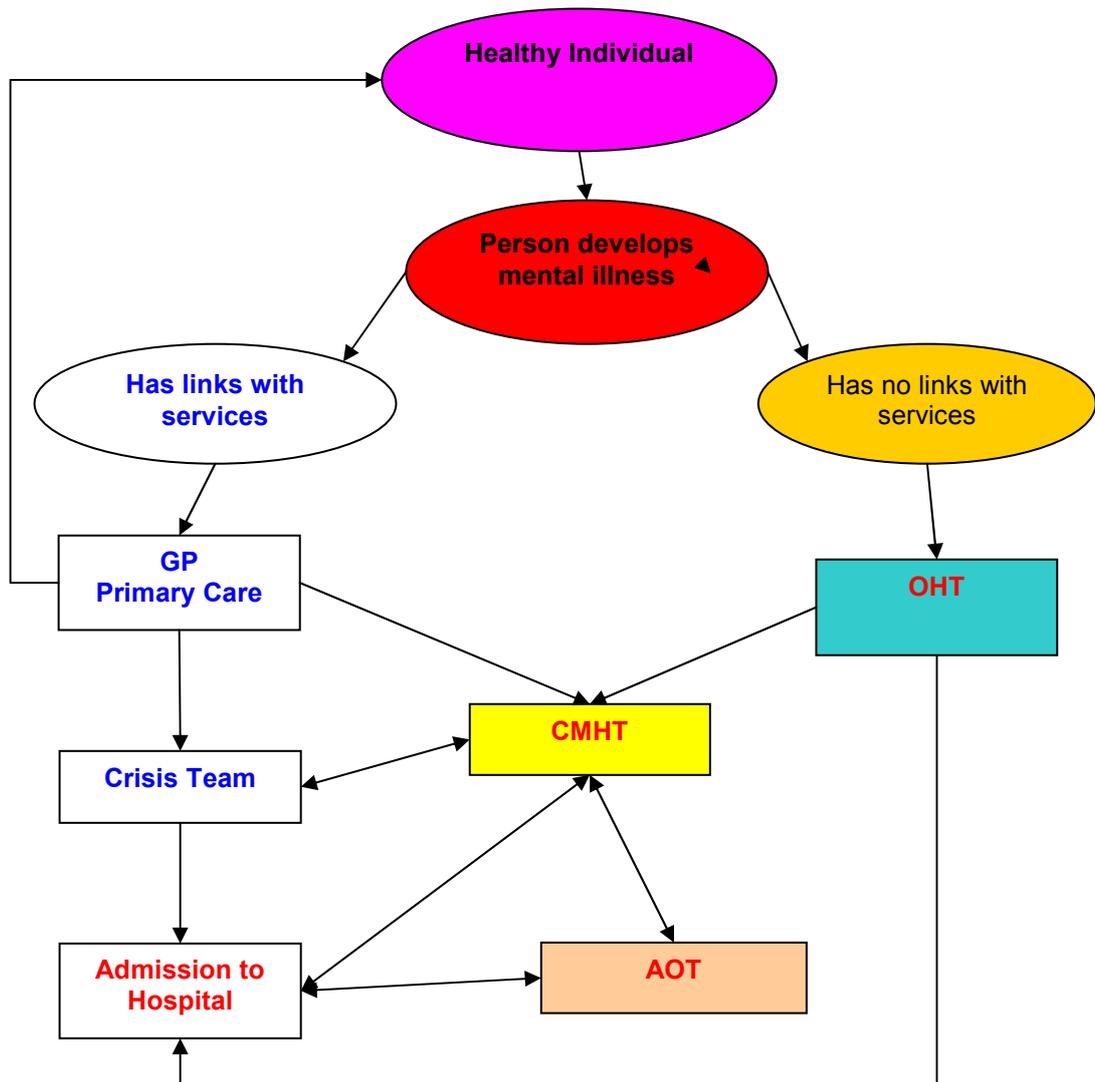
Though it is recognised that there is a small cluster of people who are not even registered with a GP, there have been few studies which have focussed on this group of people; they form the caseload of the outreach homeless team (OHT), the first team to take part in this study described in Chapter 3.

Those patients who get to the GP but whose illness is too complex to be treated in primary care and also those patients who need additional psychosocial care are referred to the CMHTs at the secondary care level, unless they need immediate hospitalisation, after which they are discharged to the CMHTs – described in Chapter 5

Some patients disengage on discharge, rapidly deteriorate and get readmitted to inpatient care. A small number of them continue to refuse help in the community and fall into a cycle of admission and discharge. They are taken on by AOTs, who persist with them, until they are able to engage with mainstream services when they are referred back to the CMHTs – described in Chapter 4

The care pathway for mentally ill patients is illustrated in **Chart 6-2**:

Chart 6-2 Care Pathway of the Mentally Ill Patient



Within the referral pathway, the Outreach Homeless Team (OHT) sits outside the formal healthcare structure. This team concentrates its efforts on reaching out to those mentally ill patients who have no links with any part of the care system, apart from occasionally accessing transient accommodation such as night shelters. In attempting to bring them into the folds of the healthcare system, staff focus on getting them settled in some sort of reasonably permanent accommodation, after which they are registered with a GP and ultimately referred to the CMHT. With some influence from the assertive outreach principles developed in the US, the team was started long before AOTs became popular in the UK. It was set up to address the mental health needs of the homeless population

in a busy inner London area. As described in Literature Review (Chapter 1), a few papers have been published by the consultant psychiatrist of this team in addition to those by Lehman et al (1999), which have demonstrated that this method of working provides a cost-effective approach to reducing homelessness among persons with severe and persistent mental illnesses.

The second team to take part in this research was the Assertive Outreach Team (AOT) which sits at the tertiary level of mental health services beyond inpatient care. Patients referred to this team have systematically progressed from their GPs at primary healthcare level into secondary mental health care and the inpatient system before being accepted into it. This team in turn may use hospital beds and other support services but focus their creative skills in bringing disengaged patients into mainstream secondary mental health care. As described in Chapter 1, there are several studies into assertive outreach method of working in addition to several papers written about the various aspects of this particular team, who have concluded that it is effective in reaching those clients who disengage and are at potential risk of falling through the net. Their studies found that there is greater user satisfaction, better quality of engagement and better follow-up rates in this team compared to secondary MH services in this area of London.

The third team in this study was a Community Mental Health Team (CMHT). CMHTs make up a substantial part of secondary mental health services. As a gateway into specialist mental health care, they hold large case loads and are linked into most aspects of the statutory, private and voluntary mental health projects in the community. In addition to those described in Chapter 1, Roberts et al (2005) published a review of the economic evaluation of community mental health care which concluded that care in the community dominates hospital in-patient care and achieves better outcomes at a lower or equal cost.

Though their conclusions did not pinpoint the type of community care that was most cost effective, one particular study found that despite their substantially larger and more generic caseloads, this CMHT, like the others in this part of London, is cost effective in

terms of reduced usage of inpatient beds and improvement in the clinical and social functioning of mentally ill clients in the community.

Pattern of participation in this study

In trying to understand the pattern of participation by teams and workers in this research, I was particularly struck by the issues involved. The increasing numbers of people seeking help for emotional and mental disorders combined with shrinking budgets and resources meant that there were more demands, especially on CMHTs, as the teams were expected to absorb the soaring numbers and take on more work whilst also absorbing cuts in staffing and other resources. Following the publication of the NSF for MH, many London areas had set up assertive outreach teams jointly within health and social services or in partnership with a local voluntary organisation. At the time of this study, a number of them were being disbanded and their functions were being brought back into the local CMHTs, with internal reorganisation, relocation and constantly changing practices causing a lot of disruption across the whole service. It is surmised that this was one of the two major factors that influenced whether teams were willing to take part in this study.

The other factor was how well the teams were functioning and hence how confident they felt about being 'found out' by a researcher. The reluctance to take part in this study was thus less unusual than the willingness of the teams who took part. The OHT and AOT stated that they were used to having visitors to the team and were also comfortable with the idea of taking part in the research as they felt that this was good for them. All the teams had been previously studied and been acknowledged as 'good' services.

Table 6-1 Staffing and participation data from the three teams

Details	OHT	AOT	CMHT
Age range of participants	30 - 50	25 – 45	25 – 65
Total number of wte staff in each team	14	12	16
Average caseload individual staff	16	12	24
No of participants from each team	13	09	11
No of black staff who participated	01	02	04
No. of participants in observations only	03	01	0
No. of participants in interviews only	04	0	01
% participants in both interviews & observations	55%	89%	92%
% participants in fulltime work in team	54%	78%	90%
% participants in further studies	0%	45%	18%

The pattern of staff engagement in the study was also interesting in that, during the first visit to meet the OHT, one staff member immediately made an appointment to take me on a visit with her, while another staff member agreed to be interviewed on my first day of data collection with the team. In the AOT, throughout my stay with the team, there was pointed discussion at the end of the clinical team meeting as to who was going to be observed or interviewed by me on that day. Within the CMHT, during my first two weeks with the team, I could not get any staff to let me observe or interview them. However, once the ice broke, there was a steady stream of participation, with the result that this team had the highest number of participants in both the observations and interviews, with a comment from the manager that:

Staff have been talking to me about their experience with you - thank you for coming - the team have really appreciated your presence - being listened to - having a space to think – they have found your methods help them think of issues they don't normally think about and yet they have not found your presence challenging or interfering - please give us some feedback when you are done with the research.

Membership

Each team was made up of a range of staff with different numbers of practitioners from the core disciplines such as nursing and social work, employed either by health or social services. The two authorities had pooled their budgets and other resources in order to optimise service provision to address the needs of mentally ill people in their areas and to

fulfil their statutory obligations towards them. Despite the differing ethos of the two funding agencies and differences in the focus of care within each profession, all three teams had distinctly identified objectives. The assortment of staff from different disciplines could potentially get into competition and conflict in the pursuit of different objectives. Each individual group of staff from different disciplines are trained to target certain aspects of patients' lives and strive towards particular areas of achievement with them. While acknowledging that working within these teams evokes anxieties which spawn the duality of healthy and unhealthy defences, the teams were also striving to unify the aspirations of all these sub-systems and nurture the common primary task of caring for severely mentally ill people in the community. The AOT had the complete range of staff including two unqualified workers, although the consultant and psychologist were part-time posts. The staff in this team were predominantly nurses at various grades. The Outreach Homeless Team had equal numbers of nurses and social workers, with just two occupational therapists and no psychologist. The CMHT had equivalent numbers of social workers and nurses, with a part time psychologist and no occupational therapist. In size, the AOT was the smallest with just 12 staff whereas the other two teams were broadly similar in size with between 14 -16 staff on the whole. Though Government guidelines suggest a caseload of between 10-15 for AOTs and about 35 for CMHTs, the average case loads in these teams were 15 in the OHT, 12 in the AOT and 24 in the CMHT. All teams were struggling to maintain these numbers but, as can be expected, the biggest struggle was within the CMHT. In considering the effects on patient care of differing case loads, the review of Burns et al (2007), supported the value of small case loads for the comprehensive care of persons with severe mental illness. Finding it difficult to interpret the effects for caseloads above 1:21 and below 1:9, they felt that although there is no evidence that certain caseload thresholds triggered different ways of working, they commented that for caseloads of above 1:35, two-thirds of the contacts were explicitly medical with planned therapeutic activity being difficult, even if it was made up of a mixture of intensive and less demanding cases.

Staff from all the three teams appreciated the management and other support within their teams, although interviewees from the OHT pointed out the need for more direct help to

deal with the psychological impact of their work – Chapter 3. In terms of vacancies, the OHT had vacancies in contrast to the other two teams. Staff in this team also said that a number of them had just returned from long periods of sickness. A large number of staff in this team worked part-time, in contrast to the few part-time staff in the other two teams. A majority of the participants from the OHT talked at lengths about other things they did, apart from working in the team, in contrast to those in AOT who were preoccupied with post-qualifying courses, whereas those from the CMHTs worked full-time in the team. The data was not sufficiently deeply analysed to discern the differences in the experiences of the two unqualified staff from the AOT. Considering the ethnic mix of participants, the only black staff member (out of 14) in the OHT and the two black staff (out of 12) in the AOT participated in the study, whereas in the CMHT there were proportionately more black staff (6 out of 16), of whom 4 participated. When asked whether there were special issues about being black in the teams, participants in the OHT and AOT said that they did not think about it, whereas one of the CMHT staff spoke at length about feeling discriminated against by management and colleagues and getting very little support, apart from some of the other black colleagues in the team. With regard to the cultural needs of patients, Carpenter and Barnes (2001) point out:

'People with mental illness are likely to experience disadvantage on the grounds of social class, unemployment, poverty and homelessness. Many will also experience racial and sexual discrimination within mental health services as well as in the communities where they live. Effective MH services must address all these issues.' (p417).

Accountability

Tyrer (2001) points out that the major reason why community care has been promoted in psychiatry is that *'it is considerably cheaper than hospital care.'* (p69). Although the NHS Executive emphasises that needs assessments should underpin the planning, development and evaluation of MH services, legislation and policy continue to focus on the management of clients requiring little emotional involvement between workers,

services and clients. The goal of assessment is to address the social and political interests in safeguarding both the public and the individual patient. In order to ensure that this emphasis is adhered to, the Department of Health document *'Working for Patients'* (1989) described its duty to scrutinise health services as:

'The systematic critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome for patients' (p1).

Guidelines are regularly produced by a number of organisations, such as the National Institute of Clinical Excellence (NICE), and the Royal College of Psychiatrists, for different aspects of evidence-based treatments, while other regulatory bodies, such as the Mental Health Act Commission, produce and monitor standards of care in mental health.

The participating teams are regulated by the LA, the PCT, and the DH. The local authority require data such as the ratio of all referrals to people actually taken on, the time-scales and number of initial assessments completed and the number of clients receiving services, in order to ensure that they are fulfilling their statutory obligations to offer an assessment to anyone in 'need' and to use limited resources to make 'Best Value' judgements about services. With a view to ensuring that local populations have access to the services they require, and, that service standards are good, the PCTs collect data, such as the waiting periods between referral, assessment and decision making, number of serious incidents and the number of patients visited within seven days of being discharged from hospital. In order to have an overview of services and identify the need for service improvement, research and adequate policy development, the Department of Health collate data on matters such as bed occupancy, waiting times, the number of patients with copies of care plans, numbers of complaints received and dealt with and so on. In addition to this, MH Trusts submit the Mental Health Minimum Data Set information to the Department of Health. This looks at the number of patients admitted, the average length of stay in hospital, etc. These are broad outcomes for whole services only, but outcomes for individual patients are measurable through failures when patients make complaints. The DH, through the Healthcare Commission, publishes

an annual health check for each of the Trusts, rating them according to their adherence to set standards and their capacity for improvement. However, it has to be noted that these datasets are for whole Trusts, encompassing all the services they provide without distinguishing between individual teams. Even Trusts and Local Authorities, who are able to distinguish the performance of individual teams, will do so only if there are particularly spectacular failures, when an action-plan is demanded and the subsequent improvement monitored. A review of the variation in activity and resourcing levels in relation to patient needs and comparing and benchmarking mental health services in London was published in 2006 by the London Health Observatory. This identified that both the inner London areas in which these participant teams were based were providing top levels of care.

Websites of both Trusts did not contain any statistical and other performance reports about these particular teams. Brief interviews were held with senior managers from the two Trusts and service commissioners from the two local authorities (LAs) and primary care trusts (PCTs) to elicit information about accountability and performance. Further internet searches and telephone discussions with personnel from the Department of Health's NHS Information Centres, to gain an understanding of their regulatory functions, revealed that information is collated from services in order to identify the need and demand for services, plan service provision, including the introduction of new service models to achieve the Government's policies for access and choice, commissioning of services and reimbursement for the provision of these services, monitoring and performance management, audit of the quality, value for money and effectiveness of services and research to inform development of new services and treatments (MHMDS, 2008). As the DH Head of Information said to me, *'It enables a national overview rather than pin-point the effectiveness of particular services – unlike in other health areas, it is hard to judge concepts such as 'episode of illness', 'successful intervention' or 'cure' in mental health'*. Staff from the CMHT talked elaborately about their struggle with having to input data for the two statutory employers, whereas managers from the other two teams merely alluded to similar difficulties for their staff in fulfilling these obligations. Tansella and Thornicroft (2001) point out that, at the individual patient level, the principle accountability refers to the element of responsibility within the relationship between staff

and individual patients, a relationship that needs to be based on confidence and trust, e.g. duty to care and patient confidentiality; while the services are accountable to the public. The accountability of each individual staff for their practices and omissions is monitored, both through systematic audits of their files and other activities. Staff in all these teams receive management supervision from the team managers, and specialist groups such as psychologists also receive special profession-related supervision and appraisal from senior staff within their own professional groups.

Management

Being jointly funded, all the teams have a single management structure with the manager in the OHT and CMHT being employed by social services, whereas in the AOT the manager is a nurse employed by the NHS Trust. These managers had line-management responsibilities for staff that included the eight key management tasks as described by Ovretveit (2001) 1) drafting job descriptions 2) interviewing and appointing, 3) introducing the person to the job; 4) assigning work; 5) reviewing work (holding accountable); 6) annual performance appraisal and objective setting; 7) ensuring practice quality, training and professional development; 8) HR procedures such as disciplinary actions. During their interviews, all three managers talked about their role in maintaining the funding for their teams: in the OHT, the manager and consultant came back from a meeting to say that their funding had been secured for the foreseeable future; the manager in the AOT was busy preparing a presentation to senior managers to justify the continuation of funding for his team; however, the manager in the CMHT said that although there had been cuts in posts when the other specialist teams had started and more recently there had been freezes on a few posts without the corresponding decrease in caseloads, there was no direct threat of disbanding the team. There is varying degree of direct client work between the managers in the three teams, in that the manager in the AOT undertook some amount of direct work with clients, the CMHT manager got involved as the senior on duty or when she covered for one of the staff during their absence, whereas in the OHT the manager rarely got involved with face-to-face work, except for joint crisis visits and while fielding calls during the clinical team meetings.

All three managers had good dependable working relationships with the team consultants and in turn the two consultants interviewed, had a healthy respect for these managers. The consultant in the OHT admitted that he constantly reviewed his own work-routine based on feedback from the team about their requirements for his availability and support. Within the AOT, there had recently been some instability in the availability of a consultant, but the team acknowledged that the new consultant, who had gone on maternity leave within months of being appointed, worked very well with them. In the CMHT, there was congruence in the responses to questions between the consultant and the team manager indicating a close and effective leadership team, as discussed under Staff Qualities in Chapter 5. In comparing the effectiveness of the leadership roles within the three participant teams, it was believed that the CMHT was the most effectively managed team in terms of having joint management structures in place to maintain reasonable caseloads for staff compared to the national average of 25-30 and government guideline of 35 cases per whole time staff. Despite having less structured supportive elements, it was the most stable team in terms of there being no external threats of funding withdrawal and relatively fewer internal issues such as vacancies and long-term sickness. Leadership elements such as keeping the team together and ensuring the continuity of the team by holding the boundaries and dealing with the internal hierarchies and liaising with the external organisations, were shared between the Consultant and the Team Manager supported by other senior staff. Toasland (2007 p199) states:

'Lenman (1998) drew the distinction between holding and containing - she differentiated between the passive process of holding and the more active process of containment. Lenman argued that containment involved both conscious and unconscious processes.'

Although these two functions are equally significant and jointly shared between the managers and consultants, the effectiveness of this was questionable to some extent as evidenced by the statements of the OHT staff and the discontent of the black worker in the CMHT.

Care Pathways and decision making

These teams have clear referral and care pathways that link them within the mental health system as described in charts 6.1 and 6.2 above. In comparing these, the OHT receives referrals from outside the healthcare system and endeavours to bring clients into the folds of the mental health services. The AOT deals with referrals of people who have been through the system, but have disengaged from it, whereas the CMHT sits in the middle of the secondary mental health care system receiving and holding referrals from a number of sources. Unlike the AOT who take on only SMI patients, and the OHT who took on those with no-fixed-abode, clients were referred to a CMHT for two main reasons: 1) when they themselves seek help due to distressing symptoms or the longer term effects of medication or symptoms, such as difficulties with housing and benefits, and 2) when they are forced to receive specialist help by statutory agencies, such as the courts and child protection teams. This results in excessive demands on the CMHT from a range of clients, from the 'worried well' to those with frank psychosis; and non-cooperation from those who probably require more support, as they are more needy and less able to look after their affairs, but who feel coerced to see staff. Both the demands and the rejections cause stress in different ways to staff. All teams follow a similar procedure of considering new referrals, allocating them temporarily for assessment, deliberating on their suitability based on assessments and allocating the clients for ongoing work, and on completion of specific tasks, moving the clients out of the teams. From the OHT and AOT this final move is into the CMHT whereas from the CMHT, the clients are moved back into primary care.

These teams are highly-regulated by elaborate hierarchies in both the employing agencies so that ensuring the need for services to focus on de-stigmatising mental illness, promoting the dignity of self sufficiency and improving the quality of life for patients and making a majority of the important decisions is held at joint meetings between service directors of the two agencies. However, decisions for the day-to-day administration of the team are made mostly by the manager and the senior practitioners. The consultant holds overall responsibility for the treatment and care of the patients but

collaborates with the managers in addressing team issues and taking a lead in maintaining structures which monitor the performance of the team. For instance, both the consultants spoke knowledgeably about the gaps in the team's provision and also the current issues for front-line staff. They pointed out that the system of care coordination facilitates staff to manage independently so that teams should become less consultant lead/driven, showing a clear acceptance of the professional competency of their non-medical colleagues and the changes in their own roles and responsibilities.

Staff in the OHT and AOT demonstrated the ability to function at a high level of professional independence, occasionally turning to the consultant for advice, whereas in the CMHT, staff continuously depended on the consultant for directions and decisions, especially with regard to the care and treatment of patients. Although, the consultant himself felt:

You can only be responsible for what you can do – and that's been acknowledged by the GMC as well – if there's someone inexperienced in the team I try as much as possible to keep the standards – to be aware of all that's going on – but if someone is inexperienced or lazy or doesn't do what they should and they don't inform me and one is not aware of it - then its their responsibility – not mine.

In terms of achieving their objectives, staff in both the OHT and AOT are able to provide a range of skills and depend on external agencies only in terms of accessing their facilities such as housing and day-care. Being set up to develop a relationship and engage their clients with the system, staff have frequent contacts with clients and attempt to meet them at a place and time suitable for them, often using these visits to enhance their social inclusion by using social and leisure facilities in the community. In addition to increased frequency of visits which are daily and sometimes even more, involvement with every client is over a long period to ensure their engagement and gradual acceptance of mainstream services. In comparison, staff in the CMHT provide less direct work as they operate a brokerage model, whereby clients are referred to a number of services outside the team, so that staff are mainly responsible for co-ordinating and evaluating the care that clients receive from these various agencies. Unless clients are breaking down, they

are usually seen no more than once or twice a month. Involvement is time bound as the team's aim is to settle the clients over a short period and then to discharge them back to their GPs, with the understanding that they can be referred back to the team should a need arise again.

Comparison of core data from each team

Though similar methods were used to collect data in all the three teams, the number of participants differed according to their willingness to agree times with me during my core research time with their team – this was the time that I spent with the team observing the team meetings, which was limited to 6 weeks with each team. These observations occurred on the same day of the week, which meant that I missed certain part-time staff who were contacted later. This was followed by return visits on a number of occasions to each team, to complete visit observations and interviews as previously arranged with individual staff. Themes from each of these methods were drawn, based on the most frequently occurring topics within that dataset.

Table 6-2 Emergent Themes from Data Analysis

Team Meetings			
OHT	Nature of clients	Treatment Interventions	Support for Staff
AOT	Team Approach	Treatment Interventions	Support for Staff
CMHT	Nature of clients	Treatment Interventions	Support for Staff
Visit/Observations			
OHT	Staff Role	Staff Skills	Counter Transference
AOT	Staff Role	Staff Skills	Counter Transference
CMHT	Staff Role	Patient Characteristics	Counter Transference
Interviews			
OHT	Nature of Work	Staff Qualities	Stressors and Supports
AOT	Patient Characteristics	Staff Qualities	Stressors and Supports
CMHT	Risks and Audits	Staff Qualities	Stressors and Supports

Further detailed comparisons of these themes are made in the later sections of this chapter following a brief comparison of the basic characteristics of the teams. The following differences were noted which broadly grouped the OHT and the AOT and segregated the CMHT; both, in their structure and practice; and, in how contained and supported staff felt.

Table 6-3 Differences in Team Make-up

Details	OHT	AOT	CMHT
Caseloads	15	12	24
Nature of Clients	Diagnosis of MI	SMI	A range of mental and behavioural disorders
Model	Eclectic	Medical	Medical
Practice	Team Approach	Team Approach	Individual caseloads
Philosophy	Direct engagement	Direct engagement	Coordinating care and monitoring services
Nature of work practices	Support from Colleagues initially and as and when	Involvement of whole team throughout the process of involvement	Individualised work with very little contact or sharing with colleagues

Though conclusions such as the effective functioning of the teams were partly drawn from information in the team questionnaire and the feedback received from staff on presentation of the findings in their team, it has not been possible to directly include detailed information from these data sources due to time and space constraints. These factors have to be taken into consideration in contextualising the findings of this study and applying them to staff across all community mental health services.

Themes in the team meetings

Totally, there were 19 team meetings observed – six on a weekly basis in each team and an extra Friday evening meeting at the AOT. The content and processes of these meetings differed so that; in the OHT the format was led by staff with the expectation that new assessments and concerns about existing clients would be discussed voluntarily by staff; the AOT had an agenda which was strictly adhered to, consisting of staff concerns, client reviews and plans for the day; the CMHT also had an agenda that focussed on new assessments and concerns about existing clients, though sometimes other team

business was also discussed. Within these meetings, a common discussion was about the treatment interventions that they could offer to the clients being presented. While there was substantial discussion about the nature of the clients in the OHT and the CMHT, the focus in the AOT was much more about how the team approach could be applied to respond to their needs. The behaviour patterns of staff eliciting support in these meetings also became evident in the analyses of these observation notes.

Table 6-4 Meetings by Team

Details	OHT	AOT	CMHT
Frequency of clinical meetings	Weekly	Daily	Weekly
Manager attended	No	Yes	Yes
Consultant attendance	Sometimes	Yes	Yes
Content and process	Fluid	Fixed	Flexible
Attendance of external consultant	Monthly	Fortnightly	None

Nature of Clients/Team Approach

These discussions showed that the OHT and AOT looked inward as to what the teams themselves could offer to clients (Nature of Clients). In the AOT (Team Approach), decisions about interventions were made by the team as a whole, but a major part of the discussions centred upon whom in the team was most suitable to offer each intervention. In the OHT, the team contributed to the decisions, but expected presenting staff to offer the interventions, although less frequently other staff got involved. In the CMHT, there was considerable knowledge about community resources and the meeting deliberated on access to the most appropriate ones to respond to the clients' needs. In the OHT and the CMHT there were extensive discussions regarding the nature of the clients and detailed exploration of their varied needs. The AOT which focussed on engaging their clients, only took those with very severe psychotic illnesses so that their needs were almost predictable; the OHT addressed mental illness only as a small core of the layers of problems they had to first address from an endless list such as traceability,

accommodation, physical health, addiction, offences and health and safety; whereas the CMHT were referred clients with the largest range of mental illness and resulting problems, spanning anxiety and panic attacks at one end of the spectrum to severe personality disorders and chronic psychosis at the other.

Treatment Interventions

In comparing the treatment interventions offered by the three teams, the OHT (Chapter 3) take on clients who are most difficult, both in terms of their non-engagement and their complex needs and because they are entirely unknown, very chaotic and many times, untraceable. The team's main preoccupation is to get to their elusive clients – tracing them to where they may usually be found. Staff made painstaking efforts and went to elaborate lengths to engage clients in attending to their own health and safety and accessing services such as basic shelters. The staff are very independent and only use joint visits with colleagues when faced with potential risks. Though they all show a lot of respect for and trust in the consultant, and discuss their dilemmas with him, their work does not entirely depend on his involvement. Thus, of the three teams, this is the team which is most aligned to the social model of care in which clients' difficulties are seen as being caused by their social circumstances so that intervention is focussed on improving the environment of the clients.

The AOT (Chapter 4) spend a considerable amount of time and effort ensuring that clients get their medication. This is particularly interesting because this team had the least availability of doctors, with only a part-time consultant and senior house officer on training rotation. More staff in this team have specialist qualifications in psychosocial interventions but make direct use of it only occasionally, mainly using involvement in practical tasks as a way of engaging their non-compliant clients. All clients are deemed to have complex psychosocial needs and responsibility for the entire caseload is held at the team level. Further, attempts to minimise risks are made by carrying out a cycle of reviews of the safety, health and wellbeing of their clients. This team uses a combination of the medical and social models of care. Its sway towards the medical model is evident

in its heavy reliance on medication to achieve improvement in the clients, so that their difficulties are predominantly attributed to their illness, which is also seen as affecting their ability to achieve an acceptable quality of life. Social care is evident in the attempts of staff to get involved in other aspects of their clients' lives which are affected by their illness.

The main intervention within the CMHT (Chapter 5) is making thorough assessments of the illness and its effects, by liaising extensively with a number of relevant services in evaluating the risks to and by the client. The other intervention is to match the client's needs with the resources in the community, arrange access and monitor the subsequent usage. Almost, 50% of the team's caseload is entirely held by doctors with no involvement of other staff. With the rest of the cases, non-medical staff hold the main responsibility for care. Although the interventions are focussed on finding suitable resources in the community to address the needs of patients, the consultant psychiatrist figures conspicuously in making these treatment decisions. Despite their involvement in the psychosocial aspects and practical tasks, this team leans more towards the community model of medical care rather than a social model, as they seek resources in the community to address needs which are seen to be a consequence of the illness.

Humour played a different role in each of these teams. For instance, the OHT staff used it as a coping mechanism against the guilt experienced by them in abandoning the clients while indulging in holidays and self-enjoyment. Complaints of clients were mutually understood by staff in this light. Whereas in the AOT, it was used to enhance the description of patients' behaviours and to mask the anxieties these behaviours evoked in staff, as they sought resort in increasing input for clients e.g. by identifying it as the need for formal assessments. However, laughter in the CMHT was evoked by descriptions of the way patients presented and the effect this had on their environments. After briefly indulging in making fun of the ineffectiveness of other public services where their clients were employed, staff continued with their business.

In these teams, the jokes themselves did not centre on patients as the negative object or as bearers of negative emotion so that they were not the actual objects of mockery. On

the other hand, jokes were used by staff as a way of distancing from the patients and a distraction from the intensity of their experiences. It was also seen to be integrative in that, it was used as a way of sharing experiences where staff themselves felt at a disadvantage – a way of discharging the intense emotions involved in this work.

Staff Support

In comparing the support for staff, all three teams identified the clinical meeting as a source of support for their day to day work. In the OHT, (Chapter 3) this is a weekly meeting and all staff available on the day prioritised it even when there is no doctor attending it. The manager did not attend this meeting but once in every four weeks an external consultant attended to facilitate reflection on their work. Staff value this meeting both for support and to learn from the skills and qualities of more experienced colleagues. In the AOT, (Chapter 4) this is a daily meeting, compulsorily attended by all the staff including the managers and the consultant. Though the staff value the external consultant who attends every fortnight, they use the meeting on an everyday basis to put their disturbing experiences with clients into perspective. In the CMHT, (Chapter 5) though the managers met for a few minutes each morning to plan the activities of the day with the staff, this weekly meeting is used as a space to consider information and plan treatment interventions. Staff use this meeting to appraise the consultant about the clients' situations and elicit his views regarding their concerns about those, so that it is well attended when the consultant is available.

Themes in the observations of visits

In total, there were 27 staff observed during their visits, 33 patients were seen although there were 11 others who did not attend their appointments. The pattern of observations is illustrated in Table 6-5 below:

Table 6-5 Client Attendance at Appointments with Staff

Teams and details	OHT	AOT	CMHT
Number of staff visits observed	8*	9**	10
Total number of clients seen during visits	8	12	13***
Number of patients who DNA appointments	2 ****	2	7
Percentage of cancelled appointments	25%	17%	55%

* During one visit to the ward with the CPN, the client did not agree to be observed but the detailed discussion with the ward staff was observed

** The manager in this team did direct work with clients and was included in the observations

***Two clients did not wish to be observed during their appointments with the consultant but two other clients were observed with the consultant

**** Both these clients did not attend their appointments with the consultant who was however, observed with a third (new) client.

Though in the OHT one client expressly refused to allow me to observe his brief interaction with his care coordinator and two clients did not attend their appointments with the consultant. Only one of the other workers had arranged two appointments to ensure that I observed at least one contact: I observed both. In the AOT, two clients were not available in their flats at the time of their appointments but staff had arranged to visit other patients during these visits so that three staff were observed with two clients. In the CMHT, out of the 7 patients who missed their appointments one did not attend his appointment with the consultant; two were not in their flats at the time of the visit, whereas 4 called to cancel their appointments. Whereas in the other teams clients were just absent with no active cancellation, a larger number of patients who do not keep their appointments with the CMHT, phone to cancel their appointments. Gauging by the reactions of the staff, such cancellations seemed to be normal in this team. It is also an indication of the capability of the clients to manage without their appointments with staff.

Staff Roles

Staff in all three teams get involved in practical tasks as a form of building a relationship with clients, clearly indicating the difficulties mentally ill patients experience both in forming relationships and in attending to their day to day tasks in the community. In the OHT, in encouraging clients to engage with and use relevant services, staff struggled to maintain the delicate balance in several areas of their relationships with their very chaotic clients, whether it was respecting their privacy or accepting their ability to make decisions about areas such as physical health and their living conditions. Staff in the OHT lack the conviction that the hospital is the best place for sorting out their clients' confusion. Their role was to make contact and engage clients with various resources to address the identified need in every aspect of their lives. The AOT is specially set up to prevent hospitalisation, so staff offer greater frequency of visits focussing on medication and achieving compliance in engaging clients with mainstream services. Frequent client and CPA reviews are a major preoccupation. The efforts of the CMHT is concentrated on minimising the need for inpatient care by completing assessments in addition to coordinating their client's care by advocating for and monitoring their access to resources.

Staff Skills/Patient Characteristics

There is a subtle difference in the skills required to work in each of these teams. Workers in the OHT primarily need tolerance to the chaos, and the ability to use of creative ways to attract and hold the attention of their clients. They need to continue persistent efforts to make contact with their clients without personalising their elusiveness and constant rejection. They work with staff in voluntary and public organisations, whilst keeping their clients at the centre of everything they do. Having gained an understanding of the issues involved and ways to succeed with this client group, this team offer formal training sessions to other agencies about working with homelessness. The AOT concentrate on normalising their clients by getting them involved in 'normal' activities such as visiting cafés, discussing topics of interest to them in addition to attending to daily living tasks.

An understanding of issues generated by the dependence on illicit substances in addition to severe and enduring mental illness is important as is the need for self awareness in staff especially in dealing with clients who are very ill and have often lost interpersonal skills. Staff in the CMHT focus on patient characteristics identifying that they deal with a considerably wider range of mental illnesses and subsequently, their presentation of a greater number of issues. They hold larger caseloads and have to liaise with and coordinate the work of the whole range of community organisations who offer the services required by these clients.

Counter transference

In comparing my counter-transference to the three teams during these observations, I was struck by my unequivocal admiration for the staff in the OHT. This could be because this is the first team I observed but then it could also be because I have little experience of working with this level of chaos and damage. The other factor is that, this team had a strong ethos of the social model of care with the whole team including the medical staff being entirely focussed on the social aspects of their clients' lives. In most of the observations I was able to hold my observer stance and notice the creativity of staff in rising to a situation and remaining totally patient centred. I had high regard for their total commitment, for their joy at the smallest achievements of their clients and for their ability to pick out the positive aspects of their clients. Within the AOT and the CMHT, there was a mixture of identifying with the staff in their anxiety with some patients and allowing myself to experience their patients the way they themselves did, such as becoming oblivious to the patients' surroundings. In addition to consciously being aware of their aloofness and apathy, I was in complete identification with some clients, gaining some insight into their experience of the staff who participated in this research.

Themes in staff interviews

Interviews were carried out with 29 staff, including the managers and deputies in each team and the consultants in the OHT and the CMHT. The focus of the questions was slightly enhanced for the managers and consultants of the team, in that they were asked both about themselves and their management of front-line staff. While all the interviewees identified themselves as care coordinators rather than by their professions, interviewees in the CMHT vividly described what care coordination actually meant as described elsewhere in this thesis. Staff in the OHT talked about the nature of their work and in the AOT staff were concerned with the characteristics of their patients, whereas staff in the CMHT were preoccupied with the risks and audits they were subjected to. Since these themes have already been discussed above they will not be further elaborated here. However, the other two themes that were common to the interviews in all the teams were the staff qualities, and the stressors and supports staff experienced in their work. These are elaborated and compared below.

Staff Qualities

In addition to questions about what influenced them to do this kind of work and what appeal these teams held for them, managers and consultants were also asked about what qualities they would look for in staff. Staff in the OHT felt that it is most important to be attracted to this work and have a dedication to this client group - to tolerate their confusion and persevere in spite of their inconsistencies. The managers said that they looked for motivation, flexibility and an interest in doing outreach and creative engagement. Since there are few parameters for the qualities required to work in this team, all of them agreed that it required a fascination for the team's work to seek employment in it. In the AOT staff felt that they needed flexibility, both in terms of their professional boundaries and their daily work arrangements, as much as qualities such as persistence and an ability to elicit support from colleagues on a one to one basis and as a team. The manager said that he looked for a capacity to think, share, learn and take risks. The CMHT staff felt that it was important to have an interest in people and the kind

of problems they potentially faced – the variety of clients offered by the relatively loose boundaries of the team required staff to work beyond their professional boundaries with an ability to draw upon coordinating skills such as negotiating, influencing and monitoring. The senior staff said that in recruiting frontline staff, they looked for a sense of humour, the ability to remain calm and the capacity for building empathetic relationships with clients who come with a wide range of problems.

Stressors and Supports

All the interviewees responded profusely when asked about the uncomfortable aspects of their work. A majority of the staff in the OHT felt that direct work with the clients is very rewarding even with the heavy impact of coming face-to-face with the severe damage and confusion of these clients. Staff in this team are most vulnerable in visiting in the community as they trail across the city trying to meet clients with 'no fixed abode'. In order to work with them, staff need to identify with the helplessness and isolation of their clients, which increases the intensity of this impact. They felt that there is not enough support in the team to target this anxiety. They also found it very difficult to deal with the prejudice and discrimination their clients faced. Interviewees in AOT identified three sources of stress – illness related - in terms of having to witness relapse and deterioration, behaviour related - including the violence, abuse and destructiveness of clients which impeded any achievement with them, and, work related - such as having to face the violence and abuse when alone in the community and also having to constantly deal with the projections and expectations of society. As the foremost team that assessed the needs that arise as a consequence of mental illness, the lack of appropriate resources to match these needs is a major source of stress for staff in the CMHT. Another source of stress in the CMHT is having the sole responsibility for a large caseload, for a wide variety of clients' demands and for networking and liaising with staff from a vast number of services. The lack of reflective spaces to deal with the resulting anxiety and potential for greater identification with their clients was a stark contrast with the other teams. Seniors in the team seemed concerned as they commented that staff had not been able to make use of both an external consultant and the space made

available in the team meetings to discuss issues of work-related stress. Staff in the team talked about the risk of visiting patients in the absence of information about the threats they pose whether it was violence, abuse or having dangerous pets such as a python.

In talking about the supports they had in their work, all the staff acknowledged supervision and the clinical team meetings as being very supportive. Staff in the OHT felt that it is empowering to be able to use legal routes to challenge some of the discrimination their clients face. A large number of staff worked part-time in this team, so that they are able to engage in other pursuits of personal interest. In the AOT, apart from the team approach and the many other supportive team structures, staff appreciated the close relationships and informal socialising between colleagues. The CMHT felt that it is good to be able to refer clients on when the goals had been achieved for that intervention so that caseloads are kept to reasonable levels. There were a number of procedures in evidence of the recognition that staff in this team are especially vulnerable to risks in doing lone visits to new and unknown clients in the community. The awareness of these hazards does not make it any easier for the managers to balance the potential risks with ensuring that the flood of referrals are dealt with so that there are no endless waiting lists. Another issue that interviewees in this team talked about is the numerous internal and external audits their work is subjected to. This preoccupation with checking and monitoring seemed to bear stark contradiction to the fact that, of the three teams this is the only team that is not struggling to justify its existence.

Comparing discussions

Understanding an organisation:

‘ . . . requires the reconciliation of two often contradictory views of enterprise: the purpose of the enterprise as achieving efficient task performance and that the primary task of any enterprise is to satisfy the needs of those who are employed in it’ (Miller & Rice 1967 p251).

Findings have been subject to further interpretations to understand how these teams function as complex self-regulating systems to achieve the dual goals of addressing the needs of the mentally ill and providing a degree of satisfaction for staff in performing their work and holding frustrations and anxieties at bay. In striving to create a culture which encourages:

‘ . . . a sense of belonging – where membership is valued and where members themselves are valued’ (Haigh 1999 p247).

It is evident that these teams have achieved various degrees of success. The formal and informal structures in the OHT and AOT had considerable influence on establishing the ‘team-in-the-mind’ concept as described in Chapter 1, by effectively blurring the boundaries of responsibilities between individual staff and the team as a whole. The powerful influence of this way of working and in developing an ‘internal supervisor’ as described by Casement (1985 p 33) representing the team and the team meeting, is evident in the intense support that staff in these teams felt in encountering the real and imagined dangers posed by their very damaged clients. However, in the CMHT, despite the careful consideration of all the available information, patient contacts remained potentially risky due to lone working, perpetuating fierce anxieties in staff and no support from their ‘team-in-the-mind’. This feeling of loneliness is heightened by the elaborate scrutiny and audits resulting in the continuous changes faced by this team, leading *‘to a dread of being overwhelmed by anxieties and concerns both of a primitive kind and related to the work in hand’* (Healy1998) (p48).

The Primary Task of each of these teams is broadly similar, in that they were set up to address the needs of the mentally ill population within their communities and the concerted efforts of staff are generally focussed on making life better for them. Following the principle of socio-technical systems⁶, these teams are preoccupied with the necessity to be precise about what had to be done rather than how it was done.

⁶ comprising of self-regulating, multi-skilled work groups which find the best match between social and technical systems to work as a democratic organisation

Table 6-6 Comparison of Team Objectives & Primary Tasks

Primary Tasks				
	Objectives	Normative	Existential	Phenomenal
Homeless Team	Get Homeless people engaged into mainstream services	Identify and work with homeless people with SMI in the catchment area and reduce their danger to society	Engage with clients to improve their quality of life and reduce self-damaging behaviours	Normalise people on the fringe of society, and facilitate an improvement in their quality of life
Assertive Outreach Team	Address the needs of those patients who fall through the net of the services in the community and prevent relapse and readmissions.	Engage with non compliant patients and prevent frequent admissions and the 'revolving door' phenomenon	Improve compliance, minimise their resistance to treatment and ensure their survival in the community	To monitor medication and help with practical tasks to ensure the health and safety of patients in the community.
Community Mental Health Team	Offer specialist secondary care to people whose mental illness is too severe to be managed within primary health care.	Offer advice to GPs and co-ordinate the care received by the mentally ill patients in the community	Offer short-term interventions and help them to access services when patients are in a mental health crisis.	To ensure that patients do not harm themselves or others and continue to live safely in the community

This minimal critical specification of tasks enhanced the autonomy of staff to decide how they undertook to do them in a flexible manner. As highly qualified individuals, staff centred their actions in such a way that their cumulative achievements produced the desired overall effects within these teams. The team structures which have developed naturally and through deliberate contemplation promote a vigilance of the risks inherent in this work. In each team, the consultants and the managers jointly formed a hierarchy that served to hold and protect the team boundaries both by facilitating information flow internally and deflecting external pressures. The containment thus offered could perpetuate basic assumptions dependency and pairing potentially pushing these teams to dwindle into dysfunction, but this was not observed. What was seen in reality were functioning teams struggling at various stages of insight to grapple with the pressures placed upon them by the nature of their work responsibilities. In the AOT, staff were expected to achieve individual expertise but subsume their individual identities completely

into the team; but, in the CMHT staff remained as individuals, only superficially coming together as a single team; whereas, the OHT engendered a combination of these two behaviours, by expecting staff to do their day-to-day work alone but to rely quite heavily on colleagues for support. Though the expectations and structures in each team encouraged staff to indulge in these contradicting behaviours, these teams are optimally functional achieving their goals and objectives to a greater rather than lesser extent. These structures, whether naturally developed or socially constructed, offer organisational defences and cognitive frameworks to counter the intolerable anxiety arising from the nature and content of work with these client groups. It is likely that staff in the OHT and the AOT are more aware of their own identification with aspects of their clients' lives resulting in a level of distinction between their personal boundaries from that of their work, as they have more structures particularly set up to encourage reflective thinking. The extremeness of the psychotic experiences and chaotic lifestyles of their patients contrasting with that of their own also aids this separation. However, within the CMHT, the subtle nature of the patients and their problems in addition to the severe adherence to a business-like work atmosphere contributes to the restricted awareness and acknowledgement of the dangers of potential identification of staff with their patients and their anxieties.

In addressing the whole patient experience of mental illness, staff are subjected to profound projections from their patients. In addition to this, does society too project its fear and intolerance of the abnormality of these experiences onto these teams? The clinical meetings and other structures provide a space to share the conscious concerns and make plans to address these uncertainties. Foster (2001) promotes such spaces to help staff to return to the depressive position whilst acknowledging that for much of the time they need to *'split off parts of their emotional experience in order to preserve their own mental health...'*(p81). By using these splitting mechanisms at conscious and unconscious levels, these teams hold on to their identifications with the clients in their efforts to maintain their own arousal levels both to preserve their interests in the clients and persevere in their fights with a society which is in turn struggling to acknowledge these clients as an integral part of itself.

Conclusions

There is no agreed philosophy about the nature of mental illness – its causes or its treatments – there was no reference by staff to the possibility of cure - their concerns concentrating on benign containment. Though there is some move towards normalising behaviours and social inclusion, generally these teams regard 'cure' as an objective which is commonly unattainable once patients have got into the condition in which services find them. There was little evidence of any personal therapeutic work within these teams as if it is taken for granted that these patients are beyond the possibility of a return to normality, partly because of the nature and chronicity of their illness and its social consequences to them and partly because of the prohibitive cost of high level therapeutic resources. The view that the therapeutic model offering intensive interpersonal psychodynamic therapy is not suitable for this group of patients is further evident in the absence of patient-based measures of quality such as rates of recovery. Instead, management and accountability systems are satisfied with procedural proxies for these in terms of frequency of contact, numbers of serious incidents, etc. The concern then is, given their non-engagement with achieving alleviation or even suppression of symptoms, are these teams only recreating institutions in the community? Perhaps proof that:

'.....the simple fact (is) that mental illness is unbearable; that working with people who are losing their mind is unbearable. The sense of deterioration and unbearability that plagued psychiatric hospital back wards did not reflect the abuse of the mentally ill from this perspective. The unbearability of the psychiatric hospital back ward reflected the awfulness and deterioration that is mental illness. From this perspective, the function of the new mental health philosophies and models of practice was not to improve the lot of the mentally ill, but rather to manage the despair of the workers and provide the illusion of progress in an area where progress is slow.' (Morris 2000 p83/84).

This study has attempted to understand the intricate and non-linear functioning of a sample of mental health teams in the community by looking at their activities and structures and the complex relationships of these with the experiences of staff. It is entirely focussed on staff and organisational experiences rather than the patient population for whom the services are provided. The small sample of three teams that chose to take part, out of the complex network of mental health services, are located at different levels of provision within its complex system. Though they are fairly representative of these teams in the kind of service they provide, they are not necessarily typical, given the fact that they were willing to participate in the research and other teams had declined, and also perhaps due to their high levels of functioning.

One finding common to all teams and hence perhaps the reality of the mental health scene today was that staff were found to be more aware of psychodynamic issues, clearer about their roles and responsibilities; managers co-led teams with their clinical leaders, each with clear role definitions and boundaries; teams were on task and have consciously thought-through structures; and patients had clear care pathways and improved availability of resources. These positive findings are in contradiction to the findings reported by studies such as those by SCMH in the 90s.

Feeding back to the team was not particularly onerous, both because the findings were quite positive and also because the teams seemed to have a good understanding of psychodynamic concepts especially in relation to their work

In the last 10-15 years since community services became the trend in mental health, there have been numerous studies which highlighted the needs of staff and advocated vigilance against the damaging aspects of working in the community. There have also been tremendous improvements in psychopharmacology, leading to more effective drugs with less damaging side effects. In addition there have also been a series of government guidelines and legislation aimed at improving the provision of mental health services in the community. These measures seemed to have the effect of addressing issues such as the toxicity experienced by staff (Wykes 1995) making staff feel demoralised and ineffective (Paxton 1995) and resulting in staff burn-out (Moylan 1994). The

homogenisation of roles and the extension of care management responsibilities and access to (local authority) resources to all staff has improved relations within the teams (Biggs 1991). However this obliteration of professional boundaries has come at the cost of the loss of therapeutic activity for patients as described by Foster (1998c), so that the small proportion of the patients incidentally seen during this study were being barely maintained in the community with a minimal quality of life. Focusing on the sustaining qualities for staff within these teams, the common themes that emerged were fourfold: an understanding of the client group; the range of qualities and skills that staff had; the treatment techniques in use and their audit systems and accountability; an insight into the containing processes and support structures available within the teams. All the three teams were found to function well, with adequate containment of anxieties and a considerable improvement in the quality of both the facilities and the support experienced by the staff.

Chapter 7:

Conclusions and Recommendations

Introduction

In the preceding chapters I have described the relevant literature and research data, dealing with the methodological issues and substantive findings from the three teams which participated in this study and comparing the findings. In this chapter, I shall attempt to substantiate the themes, applying existing theories to draw my conclusions and raising questions where it has only been possible to make associations and hypothesize. Nevertheless, if these reflections are to be more than just illusions and of equal use to practitioners and policy makers in mental health services alike, it is necessary to contemplate upon what attracts practitioners to this type of work, what keeps them there, what enhances their work abilities and ensures their psychological fulfilment at work. In order to facilitate consideration of these, I will summarise the themes that have emerged in the data, draw on the discussions and recommend topics for further research.

Overview of Findings

When writing the proposal for this study, it had been conceived as 'An investigation into staff experiences of working in the community with hard-to-reach severely mentally ill people'. However, as the research progressed the focus changed to gaining an understanding of staff experiences and organisational processes of mental health teams in the community.

Though there are a number of studies which have evaluated the effectiveness of these very teams in terms of client outcomes, none of them had looked at the team processes or staff practices, views and experiences. Observing staff in action, both whilst visiting their patients and participating in team meetings, followed by eliciting their views through

semi-structured interviews, several themes were identified and dynamics noted. The summary of these findings is as follows:

Small caseloads of 10 or 12 clients per staff effectively enable staff to offer meaningful one-to-one relationships to clients, whereas larger caseloads can only facilitate the coordination of their care which is provided by a network of resources in the community. Staff in the OHT and the AOT, where the caseloads were smaller and there was more opportunity to do direct work with clients, exhibited more awareness of the intra-psychic effects of doing this work. They sought the opportunities for reflective spaces to think about their work with the clients and its impact on them. On the other hand, the CMHT staff coordinated the care of their clients and so had to juggle their time between liaising with a large network of services and holding large caseloads, so that they did not have the time to consider these issues or make use of opportunities for deliberations on their work. CMHTs experienced the largest percentage of clients not attending appointments, despite the fact that most of their clients actually sought help actively from the team, in contrast to the non-compliant, difficult-to-engage clients of the OHT and AOT

The specific qualities and skills needed by staff in the three teams were also different. Staff in the OHT needed to be tolerant of high levels of risk in taking on work with clients who, in the majority of cases, were too chaotic and damaged, with no incentive for accessing or engaging with services and little further to lose if they did not. They needed to persist in tracing their clients with 'no fixed abode' and use creative methods to engage them and be able to celebrate their clients' tiniest achievements. The work was so draining that staff needed to be able to take time off to do other things in their lives. In the AOT, the most important quality was the ability to share knowledge, skills and practices with the whole team. Staff needed to appreciate the value of mediation to help their clients remain out of hospital. They needed to have an interest in further professional development – in areas that are relevant to the problems presented by their clients, in order to take the responsibility of contributing to the team's objective of making available all the relevant skills within the team so that there is very little dependence on external agencies as they endeavoured to engage their non-compliant clients. In the

CMHT staff needed to depend on their basic professional training as they individually worked with large caseloads of clients with the widest range of mental disturbances. To address illness-related issues at the same time as assisting with every aspect of their client's lives, they needed to have an interest in gathering knowledge of all the relevant resources in the community and negotiate access to them. They needed the confidence to lead a group of practitioners in the community as they organised and co-ordinated the care required by their clients.

Getting involved in helping clients with practical day-to-day tasks as a way to engage them effectively was used unanimously by all teams. As an important aspect of their role within each of their teams, this way of successfully making contact with their clients helped to create a time with the client when other things could be addressed. In this way involvement in practical issues was constructive rather than being a negative and unproductive defence. The teams used a series of joint working practices ranging from doing the initial assessment to subsequently visiting a client in crisis. However, the AOT used the team approach as the very basis of their practice and staff identified this aspect of their work as being extremely supportive.

Staff identified the need to liaise with external agencies that did not have the same statutory responsibilities or overview of the clients' lives as extremely stressful. The paperwork involved in appeasing two masters was another area of stress. Some staff from each team identified the effects of the illness resulting in violence and other self-destructive behaviours as being stressful to witness, especially before the patients became ill enough to require hospital admission. In addition to individual supervision, all staff unanimously identified the clinical team meetings as the most important supportive structure. These meetings were found to focus very much on deliberating on issues to tailor-make plans for the clients rather than being pre-occupied with meeting the targets set for the team.

The three teams were found to be effectively responding to the demands made on them by their stakeholder networks. This was evident from the fact that during the period of the research, two of the teams were successful in convincing their commissioning agencies

to continue their funding, while the third team was not under any such threat. All three teams also offered a greater degree of stability to staff who reported low levels of stress. This was further evidenced by objective measures such as low levels of staff turnover and sickness, in addition to the positive views expressed by both the senior managers and commissioners with regard to these teams.

Reflections

In addition to the liberalisation of social attitudes to mental health, deinstitutionalisation of patients was accelerated by the rising cost of maintaining or replacing old hospitals, advances in pharmacological treatments, improvements in social security benefits for discharged patients, increasing numbers of patients being admitted to hospital despite shrinking budgets, development of private care provision, the growing distinction between treatment and care and the increasing availability of professionally qualified staff able to offer psychosocial interventions in the community. Mental health services started the early 90's with little relevant knowledge of providing treatment and care in the community. However, the gradual accumulation of experience and published clinical research has built up an evidence-base for modern services to achieve more success in this area. This has been enhanced by the passing of appropriate legislation and government guidelines for providers to fine-tune their services. The contrast between the research findings published in the early 90s and the findings of this current research provides further evidence of the gradual improvement of both the quality of services and staff experiences within mental health care in the community.

Though a majority of the staff themselves felt that their professional training had helped them in developing some useful defences against 'madness', especially to function within clear boundaries between personal issues and those of their clients, the data in this study was inconclusive about the effect of professional training because in the whole cohort of participants there were only two who were unqualified.

In contrast to previous studies described in Chapter 1, the three teams which participated in this research were found to be functioning extremely effectively, judging by the team

morale and the views of regulators. All the staff were able to hold their clients in their minds and enable them to consider and sometimes even exercise the limited choices they had; for instance by helping them towards independent living by accessing housing, concentrating their efforts to make optimal use of the opportunities and the time they had with the clients to develop a rapport with them. Additional conclusions that are drawn from the findings described in the previous chapters are:

Firstly, the clients of the three teams differ in the range of severity of their illnesses and consequently their needs are different in intensity rather than in their nature. This justifies the different positions occupied by these teams in the matrix of mental health service systems.

Secondly, all the teams get involved in helping clients with practical tasks which are prioritised by the clients, as a means of engaging those who are non-compliant and sustaining the resettlement in the community of those who actively seek out help.

Thirdly, the interventions these teams offer differ according to the particular needs of their client groups and include medication and CBT at one end of the spectrum to assisting them through access to services such as housing and learning social skills such as visiting and eating in a café at the other.

Fourthly, staff find the clinical team meetings and supervision extremely useful in facilitating their day-to-day work and for dissipating the primitive anxieties inherent in this work: staff in the OHT and AOT are more contained by virtue of practicing a team approach which facilitates the sharing of responsibilities for clients.

Fifthly, with regard to stress, while staff in the OHT and AOT identified liaising with other agencies in the community as being most stressful, those in the CMHT identified this as their major function, but identified the lack of resources as a major source of stress that adds to the mental demands made by their clients.

The most important conclusion that can be drawn is about the availability of a wide range of services in the community: there was a major difference between the OHT and AOT on

the one hand and the CMHT on the other, both in their philosophy of work, including caseload size and type, and the role of staff and their feelings of containment. Earlier studies had identified the limitations of multidisciplinary staff working in the community as a team, but this study found that the staff worked well together but are their working effectively with the clients?

Questions that could not be answered

As I started gathering and analysing the data for this study, several questions kept recurring, some of which were answered by introducing minor modifications to the methodology. For instance, very early on the question of the accountability and effectiveness of these teams arose and thus I decided to include the managers of the services. However, there were other questions which could not be incorporated due to the qualitative nature of the study, such as:

1. How does one overcome the problem of the generalisability of qualitative research, which is often small scale and focussed on particular specialised social settings?
2. Whilst many of the themes occurred in all of the teams, can they be applied to other teams in the mental health services and elsewhere?
3. Can assumptions be made as to the validity of treating this participant group as a typical sample, in a statistical sense, of the community mental health staff population in general? My own experiences of a variety of similar services is that, although these particular services are at the higher end of functioning, most community MH services have similar issues and feelings within their staff teams.
4. These were stable teams: what learning may be made available by replicating this study in a team that is harangued by continuing change and other acute crises? It may be possible to compare the two types and thus determine the differential effects on staff of organisational crisis and change.

5. Would the conclusions about the performance of these teams be the same if I had elicited the views of other services that interacted with them? With the lack of value-free outcome data, it would be necessary to descriptively evaluate the qualitative views of others, unless they could provide some useful quantitative outcomes data.
6. In what way would the quality of data be affected if there were no time constraints?
7. Would the availability of evidence such as outcome measures for clients and other performance targets set by regulators influence the emphasis of these findings? If the outcome measures reflected sufficient detail, it may be possible to determine any correlation between staff morale and those outcomes.
8. How are 'Performance Indicators' set in the first place? – for instance how does the target of 'frequency of contact with clients' ensure that staff spend quality time with the clients – or make the contacts 'useful' to the client? The usefulness of such imprecise measures is extremely limited. How can they be developed into something more meaningful?
9. How might the availability of data that evaluated the effectiveness of individual teams impact on the evaluation of the performance and experience of staff? If the different factors, other than those that are staff-related, could be distinguished and factored out, this would be possible. With the limited detail of the current and likely future outcome data sets used by regulators, this will not be possible in the foreseeable future.
10. Whilst care in the community has taken away such restrictions as the institutional walls and the relative inactivity and total dependence on ward staff; it has brought about a poor quality of life, isolation and a lack of resources for rehabilitation and resettlement. Often the only networks patients access are the professionals who visit them, creating 'institutionalisation' in the community. Taking all these issues on board, how do staff aim to achieve the latest targets set for them of getting the

majority of patients into employment so that they could come off welfare benefits? Firstly, is this policy expectation realistic? Many people with SMI are severely and perhaps permanently disabled. If this target drives staff to place people in work who are not able to embrace it, even with as much support, habilitation and training as can be made available, then their failures will further damage and stigmatise them.

11. Staff and services continue to struggle with the implications of 'normalising' patients' lives in the community; for instance staff despaired of working with patients who fall prey to the vices of modern times such as wanting to 'join in' the culture of illicit drug taking. One must question the value of some elements of the seemingly unthinking universal application of its social inclusion policies, rather than using it as a valuable belief that thoughtfully informs policy.
12. Is it possible for these teams to go that extra mile to achieve improvement in their clients rather than just 'maintain' them – what factors could enhance the performance of staff to achieve this? However, there are others that limit it – resources, especially staff time, i.e. caseloads, and therapeutic skills are perhaps the most important, along with relatively unchanged public animosity to and fear of people suffering with mental illness.
13. But, if it is perfectly possible to reach and even exceed performance targets set by regulators without truly meeting the needs of customers, would the outcome of this study be the same if I had elicited the views of the patients?
14. Why do staff not protest against the quality of life lived by their clients – how does the system accept this poor quality of life for patients in the community? The answers are partly socio-psychological and partly political – the fears and stigma surrounding mental illness lead to gross denial of the issues and the need of the public to remove MI from sight so that society's projected negative phantasies can be put out of mind. MI is not an illness like cancer or heart attacks that people identify with easily, so there is little political drive to spend public money

on its research, care and treatment. On the other hand, staff who do this work because of their reparative guilt identify closely with the clients and in defending them from society are unable to be critical of their quality of life.

15. Some of the questions, especially regarding patients, that are raised above are not within the scope of this study. However, is it now time to divert our attentions from only evaluating discreet treatments and focus instead on general life outcomes? And further, how might improving staff experiences at work impact on these patient outcomes?

My learning

As a mental health practitioner and supervisor of mental health staff, this research experience has been invaluable to me. The observer role sensitised me to my own subjective experiences of the teams and the staff, and facilitated my gaining an insight into organisational culture and functioning. My knowledge of the system and the variety and individuality of the work practices of staff deepened to a great extent.

My skills of observation of both individuals and groups have sharpened and my ability to give sensitive feedback has been enhanced. This has consequently led to an improvement in my own management style. For instance, as a result of having to discuss with staff their actions during visits, I learnt ways of raising issues and making enquiries without seeming to persecute them. I have been using this in managing the projects and teams I am responsible for in my day-to-day work.

In analysing the observations and interviews, I have learnt to appreciate the fine art of the different interventions used by individual staff. The opportunity to examine my own counter-transferences has been helpful in my better understanding both staff and clients.

The use of concepts from the grounded theory with my data, in terms of systematic analysis and evaluation from the beginning of the research process, has helped me to become more organised in other areas of my life. Writing presentations for the Tavistock research seminar and for discussion with my supervisor has helped me to develop the

ability to organise and sharply target the numerous reports required in my work. I have since used both observation and feedback discussions to help staff in my own organisation to reflect on their work with clients.

Recommendations for policy and practice

In coming to terms with the fact that the above questions were left unresearched as they fall beyond the scope of this study and perhaps because I could only focus on what I had found, some hypotheses are put forward drawing on both my experience and knowledge of the field of mental health. These teams were unique in having the strong containing structures in the form of close relations between the managers and consultants which enabled their energies to be concentrated on achieving their objectives rather than be subsumed in dealing with internal strife and reflecting the confusion of their patients' lives. However, the insights gained are considered to be equally useful to practitioners and policy makers, considering the fact that more people are receiving a diagnosis of mental illness and more services are being diverted into the community and more unqualified staff are involved in providing these services.

Staff should be facilitated to move from bewilderment and burnout so they can abandon the defensive practice of concentrating all their energy on *'filling in forms and praying that the inadequate resources for comprehensive care would not result in nasty events'* (Muijen, 1996, p 153). The quest is for a substantial shift in attitude and skills from those which existed when community mental health services were originally set up, to instead view patients as people who are parents, tenants, writers, gym-instructors, etc., fulfilling every kind of role as they take or not take responsibility for their own recovery.

Focussing on the research itself, the methods adopted required the staff to describe in their own words and actions what it is like to do this work, eliciting a depth of 'softer information' which a positivist approach might have lost. In order to theorise and explicitly arrive at *'an idea about how other ideas can be related'* (Dey 1993, p51), the use of grounded theory was invaluable. This was because it required the analysis of the data, even as it was being collected, whilst increasing the scope of introducing changes in

order to ensure that the methods used facilitated acquiring data that targeted the research goals. The use of grounded theory should be seriously considered in studies which involve collecting data sequentially from a number of sources.

It should be noted that this was a cross-sectional research and that the data was collected within a single time frame. It is not a longitudinal study, so allowances should be made for the incidental anomaly of particular influences experienced by the teams during the small time frame of this study. It would be useful to undertake a longitudinal study of a number of teams to gain insights into the effects of crises and other changes on staff experiences and performance.

This research adds weight to some concepts which are reported in the literature, such as the effects of the intolerable projections of patients with severe mental disturbances and the unconscious identification of staff with their patients' pain and confusion.

Further, in contrast to the studies described in Chapter 1 in this research, it was evident that the staff enter this field of work because of their identification with their clients through these introjective processes. Staff clearly reflect on their own life events and relate to their social networks to gain an insight into the difficulties faced by their clients. The feelings of helplessness in facing their clients' symptoms of illness and their consequent social ostracism evoke an intense guilt so that staff are involved in this work as a form of reparation. A majority of the staff are aware of these processes which influenced their choice of working in these teams. However, in dealing with clients who are on the whole operating from the paranoid-schizoid positions, these workers' struggle with innate conflicts of life and *'the nameless dread of annihilation'* (Bion 1962). These instincts are further compounded by the effects of the clients' forceful and unrelenting psychic attacks – which impacts heavily on their psyche and makes working in the depressive position difficult. Policy makers need to recognise the unconscious irrational processes involved in doing this work so that more facilities including time are made available to workers to reflect on them. This is especially important for CMHT staff to gain an insight into these issues to facilitate better functioning of the teams. Teams should accommodate the need for staff to have a reflective space to understand the

nature of these challenges and to process these disturbing feelings, whilst acknowledging that the effects of working with psychosis go beyond the work situation into the personality of the worker who has to learn to contain psychosis and help colleagues to do the same.

These clients lack early containing experiences with primary objects who could process their projections for them. Faced with the bewildering symptoms of their illness, they concretely project their frightening experiences into the workers and the environment. It is therefore essential that these workers are supported to distinguish between what belongs to the clients and what belongs to them and to develop the capacity to help their clients to repossess those parts that they split off and project into others. Though these teams offer 'good enough' containment for the anxieties stirred up by work with this potential extensive damage, through the conscious setting up of structures such as clinical team meetings and making expert advice available informally and through regular supervision; it would be useful to analyse the content of staff supervision, to understand whether it contains elements of both administration and consultation which facilitates staff learning and strengthens their ability to deal with stressful situations.

Though team meetings were originally set up as an extension of ward rounds, the fact that these meetings are a common occurrence in every community mental health team is testimony to their significance in containing staff anxieties, whilst ensuring that accountability and decision making is shared. All the participants spontaneously identified these meetings as the most important structures within the team to facilitate the sharing of feelings evoked by the experiences of the inherent dangers of these projective/introjective processes. A detailed analysis of the basic assumption mentality of the teams revealed that whilst they were mostly on task, there were times when they operated from the various basic assumption positions. To ensure that they are conscious of these dynamics and to enable their sophisticated use to enhance performance to achieve their objectives, policy makers should put in place mandatory structures to support and encourage the clinical leaders and line managers of these teams to work in productive co-operation.

The real task of these teams is to contain clients who have enormous neediness and are for the most part unable to take in much in the way of good therapeutic 'food' so that they present as deeply deprived eliciting intense guilt in their workers. Staff relate their work as responding to the dependency needs of their clients, such as assistance with practical tasks to attain a quality of life out of the hospital and the containment of their anxieties. The success and viability of a team is intimately connected, not only to the techniques it uses to contain its anxiety, but also to its adherence to its primary task. But to effectively accomplish the primary task of helping clients and keeping them out of hospital, staff should endeavour to help clients achieve a level of independent functioning by acquiring the skills required for the day-to-day tasks of life in the community. This is not easy given the level of their disturbance. Symington (1986) argues that to be intently connected with the mentally ill is to expose the equally psychotic parts of one's own mind and that to do so is tantamount to bringing to consciousness the reality of the dread of 'not-being'. These teams are unusual in having the strong containment offered by a well-functioning joint leadership in the form of close relations between the managers and the consultants. Staff support structures should enable more critical examination of team functioning and a recognition of the defences used and when they are used – e.g. why they become more dysfunctional at certain times and not others as their anxiety increases.

In contrast to the studies quoted earlier, these teams have succeeded in keeping their clients in mind by setting up positive social defences in the form of structures such as only having short contacts with clients and focussing on sustaining life in the community rather than being preoccupied with 'curing the illness'. This enables staff to effectively relate to patients, whilst minimising the pathological effects of the primitive anxieties this contact evokes, so that the real purpose could be seen as keeping madness at bay. However, the level of disturbance in the patients is such that there can only be short visits which avoid deeper relationships. On the whole, practical tasks achieve quick, visible, measurable successes which are readily recognised and accepted by patients and which engage them in the processes of social re-inclusion.

These institutional defences are operated by staff who are conscious that their own 'valency' matches that of the team, facilitating their successful retention within the team. By repeatedly projecting their own psychic defence systems into the social defence system of the team and introjecting the team's social defences into their own psychic defence systems as suggested by Menzies Lyth (1988), these teams have achieved successful functioning. It would be interesting to replicate this study within all the teams in a single Trust to gain an insight into the influence of the wider organisational processes on the achievement of the different primary tasks and to contrast staff experiences in various teams with different philosophies of care.

It would also be most interesting to replicate this study in other, non-mental health but high profile teams, which are involved in equally demanding work, such as child protection, to look at how much awareness of intra-psychic processes staff have, what structures are available within them and how successful they are at achieving their primary tasks, assuming that the people who do such work and their defences may be different to those found in this study, as societal attitudes towards vulnerable children are culturally and psychologically very different.

Quantitative studies previously published have not looked at the psychodynamics of teams and the relevant psychodynamic literature had not been systematically researched. This research is unique in that it is an empirical study of community mental health workers from a psychodynamic perspective. Health and social care staff who spend a considerable part of their conscious lives thinking about their work would find it invaluable to gain a deeper understanding of what happens there. The scope for replicating this study in different work environments is endless.

Appendices

Letter of Introduction to Teams

Dear Colleague,

Re: 'An investigation into staff experiences of working in the community with hard to reach severely mentally ill people:'

I am a research student from the Tavistock and Portman NHS Trust, researching staff experiences of work within Assertive Outreach Teams.

My work involves observing a client visit by staff, attending team meetings and conducting taped interviews with staff who are willing to participate in the study. Please note that all names and other details will be anonymised and the data will only be kept as long as it is relevant for the current research

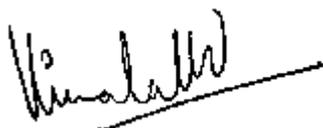
To be able to collect this data, I need to be with the team for one day a week for at least 6 weeks. My role as an observer will involve minimal interaction both with patients and staff, but I would be pleased to make any clarifications required by you or your staff.

In order to give you further information and clarify any details of my project, I would be pleased to attend one of your team meetings

I have NHS ethics committee approval for this study. I also have a current CRB check as I continue to work within mental health services.

Thanking you in anticipation

Sincerely yours,

A handwritten signature in black ink, appearing to read 'Vimala Uttarkar', with a horizontal line underneath it.

Vimala Uttarkar

Research Student
Tavistock and Portman NHS Trust

Team Information Questionnaire

'An investigation into staff experiences of working in the community with hard to reach severely mentally ill people.'

Team Information for Research

Name of the team: **Date established:**
Address:

Name of the Team Manager: Qualifications:
Contact No: Email Address:

Other senior staff:

Is there an Operational Policy: Yes/No Date of Policy:

Other Procedures:
Administrative: Yes/No Practice Issues: Yes/No

Staff Component: Please give actual numbers

Consultants: Staff Grade: Trainee Doctors:

Nurses: Assistants

Social Workers: Support and Recovery workers:

Psychologists: Assistants:

Occupational Therapists: Assistants:

Administrators:

Other: Qualified: Unqualified:

Number of staff aged between:

Under 25: 31-40: 41-50: 51-60: over 60:

Length of Service of staff:

Since Team started: Under 2 yrs: Over 2 yrs:

No of current vacancies: Locum staff at present:

Staff Sickness and other absence

No of staff sick for over three months in the last two years:

No of staff sickness days over the past 3 months:

No. of staff off for other reasons: (please specify)

In your opinion is there a high staff turnover:

Training days in the year:

Team training: Individual Training:

Profession related:

Other:

**Frequency of staff supervision:
Team Meetings:**

Individual:
Clinical:

Group:
Business:

Please list supportive meetings for Team Manager:

Type of caseload: Estimated percentage (0-100%) :

Schizophrenia:

Affective Disorders:

Personality Disorders:

Other:

Dual Diagnosis: Estimated percentage (0-100%)

Substance Misuse:

Learning Disability:

Other:

Presenting Problem: Estimated percentage (0-100%) :

Frequent admissions:

Disengagement:

Other:

Patient Readmission rates:

Percentage who have been readmitted in the last year:

None:

1-25%

25-49% 50-74%

75-100%

Case Records:

Hand Written: Yes/No

Computerised: Yes/No

File Audit frequency:

Monthly: Yes/No

Quarterly: Yes/No

Yearly: Yes/No

Incidents in the last two years:

No. affecting patients:

No. affecting staff:

Is there a clear procedure to follow in each case: Yes/No

State three things that happen following a SUI involving:

Staff:

Patient:

Information Letter to Staff

Dear Colleague,

I am a research student from the Tavistock and Portman NHS Trust. I have qualifications in social work and experience of working in mental health services within the United Kingdom.

I am currently gathering data for my thesis which is titled '**An investigation into staff experiences of working in the community with hard to reach severely mentally ill people:**'

This is a qualitative study being carried out in 4 teams. Each team will be visited for 6 weeks in order to gather my data. Data collected for the purpose of this project will consist of observing visits by staff to one of your patients, observations of team meetings and a taped interview with some staff members.

Each lot of data will be analysed using grounded theory before further data is collected. The analysis will be presented to the team for their comment which will be incorporated into the findings. Once all the teams have been visited, the final analysis will be written up in the form of a report for submission and for possible publication.

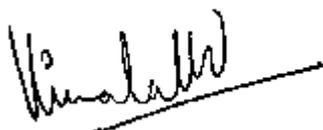
All collected data will be anonymised to preserve the confidentiality of the participants and storage of data will be according to the Data Protection Act 1998.

I have ethics committee approval required by the Tavistock and Portman Trust as a NHS unit. I also have a current CRB check as I continue to work in the field.

I enclose a consent form for you to sign should you decide to participate in my research after considering all the relevant information

Thanking you in anticipation

Sincerely yours

A handwritten signature in black ink, appearing to read 'Vimala Uttarkar', with a horizontal line underneath it.

Vimala Uttarkar

Staff Participation Consent Form

Participant Consent Form

Title of Project: 'An investigation into staff experiences of working in the community with hard to reach severely mentally ill people:'

Name of Researcher: Vimala Uttarkar

I confirm that I :

1. have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily.
2. understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason
3. understand that I will be
 - a.
 - i. Interviewed
 - ii. The Interview to be on tape
 - b. Observed during a visit to a patient
4. understand that data collected from me will be confidential and stored anonymously during analysis in line with the Data Protection Act 1998
5. understand that some quotes from my interviews may be publicised anonymously in the final report
6. understand that the findings will be presented to me during analysis and that the final report will be published in professional journals
7. agree to take part in the above study.

Name of Participant

Date

Signature

Researcher

Vimala Uttarkar

Date

Signature

When completed: copy 1 for participant; 1 for researcher file:

Information Leaflet to Service users

'An investigation into staff experiences of working in the community with hard to reach severely mentally ill people:'

Service User Information Leaflet

Dear Service User

Re : Participation in a Research Project

I am a student at the Tavistock and Portman NHS Trust.

As part of my Doctoral studies, I am trying to understand the experiences of mental health staff who work with people with complex needs in the community.

This will include interviewing staff about their practice and observing them as they carry out tasks such as visiting users of the service.

My research has been approved by the NHS ethics committee. It will not identify any of the participants.

I would like your agreement to my observing your care coordinator's visit to you.

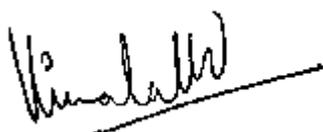
Your participation in this study will be entirely voluntary and you can withdraw your consent for my presence at any time.

Though I hope to publish my findings, you will not be identified in anyway, as all information gathered will be anonymised and kept confidential.

I enclose a consent form for you to sign if you are agreeable for me to observe a visit.

Thanking you in anticipation

Sincerely yours

A handwritten signature in black ink, appearing to read 'Vimala Uttarkar', with a horizontal line underneath it.

**Vimala Uttarkar
Research Student
Tavistock and Portman Clinic**

List of Questions - Semi-structured Staff Interview

'An investigation into staff experiences of working in the community with hard to reach severely mentally ill people:'

Guiding Questions for staff interviews:

Name (optional) :

Gender: M /F

Age :

Professional Background

Ethnicity:

No. of years since qualification:

What is your present work?

No. of years in present job:

Nature of previous work

1. Could you tell me about yourself?
2. What does your work currently involve?
3. Can you tell me about your caseload? Can you tell me a bit more about your cases?
4. What is the most difficult or uncomfortable aspect of your job?
5. What happens when a case has an emotional impact on you?
6. Do you take work home with you? Where do you go to get support?
7. What makes you interested in this type of work?
8. Do you think there was something in your background that somehow led you to doing this kind of work?
9. Is there anyone you look up to – what marks them out?
10. Could you tell me what it is like to work here?
11. How do you see the job? How does it affect your attitude?
12. What informs your practice? What are your values?
13. What was it like in your previous job?
14. Do you think that your past work experience has prepared you to do this job?
15. *For Qualified staff:* What was your training like? Do you think/feel that your training has prepared you to deal with the types of cases you currently have?
16. *For Unqualified staff:* Have you received any training to do this work? Do you feel it has been helpful in your work?
17. Is there anything else that could be relevant for me to know?

List of questions for Managers

'An investigation into staff experiences of working in the community with hard to reach severely mentally ill people:'

Guiding Questions for interviews with managers:

Name (optional) :

Gender: M / F

Age:

Ethnicity:

Professional Background

No. of years since qualification

How long have you been a manager:

No. of years in present job

Nature of previous work

How did you land in this post?

1. Could you tell me about yourself?
2. What does your work currently involve?
3. Could you describe your role as the manager of this team?
4. Can you describe your team? How are the activities in the Team audited?
5. How are risks managed within the team
6. What model of work do you follow within the team?
7. What would you like to keep and what would you like to change within the team?
8. What qualities do you value in your staff?
9. How would you describe the morale within the team how do staff continue to do this difficult work?
10. What model of work do you follow within the team? What is the most difficult or uncomfortable aspect of your job?
11. What supports do you have? Do you think they are adequate?
12. Is there anything else that could be relevant for me to know?

Data Analysis table

'An investigation into staff experiences of working in the community with hard to reach severely mentally ill people:'

Data Analysis Table

Name of Team:

Type of Data:

Date:

Passage No.	Text	Comments	Themes
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Glossary

Note: The terms '*patient*', '*client*' and '*service user*' are used interchangeably in this document, according to the usage of the particular staff member/ team or context. They are all used to describe a *person with mental health issues*.

Term or Acronym	Usage, Context or Meaning
AOT	Assertive Outreach Team – also known as ACT – esp. in US
ASW	Approved Social Worker – a social worker specialised in mental health work & trained in matters related to detention under the Mental Health Act – <i>now incorporated into the role of AMHP - Approved Mental Health Practitioner</i>
Care Home	Staffed accommodation providing significant care and support for adults which is registered and regulated by CSCI – <i>now CQC</i> - under the Care Standards Act 2000. May have a specialised focus – e.g. for people with SMI, elderly.
Care Management	Term used to describe how adults are assessed and provided with social care by local authority social services – not just specific to mental health.
Care Pathways	A map showing how people with health/ social care needs may move between different services in the health and social care network as these needs vary.
CBT	Cognitive Behavioural Therapy – a form of psychological or 'talking' treatment.
CC	Care Co-ordinator – the key role in the CPA system.
CMHT	Community Mental Health Team
CMHN	Community Mental Health Nurse – see also CPN
Commissioning	In this context, used to describe the process used to specify and arrange business contracts for the provision of health and social care services with providers of care in England. Currently predominantly the responsibility of PCTs and local social service authorities.
Consultant	In this context, only means 'Consultant Psychiatrist'
CPA	Care Programme Approach – a statutory system for co-ordinating the care of people with SMI.
CPN	Community Psychiatric Nurse – also known as Community Mental Health Nurse (CMHN)- c.f.
CSIP	Care Services Improvement Partnership – the social care division of the DH – <i>[Now disbanded]</i>
CSCI	Commission for Social Care Inspection - regulate, inspect and review adult social care services in the public, private and voluntary sectors in England. They also rate councils and, from 2008, give a quality rating to care services – <i>[now incorporated into the Care Quality Commission]</i> .
DBT	Dialectical Behavioural Therapy – a psychological or 'talking' therapy
DH	Department of Health
DSS	Department of Social Security – refers to financial welfare benefits – now re-organised as part of the Dept. of Work & Pensions [DWP]
GMC	General Medical Council – regulatory body of doctors
HCC	Health Care Commission – the General Health Care services Regulatory Body
HoNOS	Health of the Nation Outcome Scores – a rating scale of mental health and social functioning

Hostel types:

Direct Access Hostel	A hostel providing basic facilities that can be openly accessed by anyone on direct application, without any formal referral or assessment process by a care professional
Night shelter	Traditional form of direct access hostel for the single homeless.
Dry hostel	Specialised hostel or care home providing rehabilitation for people recovering from drink and or drug abuse. Abstinence is required
Wet hostel	Staffed accommodation for people who continue to drink and take drugs
MH	mental health
MI	mental illness
MHA	Mental Health Act
MHAC	Mental Health Act Commission – the regulatory body responsible for people detained in hospital – <i>[now part of the CQC]</i>
NICE	National Institute for Clinical Excellence – determines and recommends the most effective treatments for all forms of illness, including mental.
NIMHE	National Institute for Mental Health [England] – then part of CSIP – c.f.
NSF	National Service Frameworks for various services, in this instance mental health – descriptors of services required.
PCT	Primary Care Trust – main commissioner of health services
Referral pathways	A map showing how people in need might be referred into health and care services
Risperidone	A modern drug treatment used for many SMIs
SCMH	Sainsbury Centre for Mental Health
Sec 3	Refers to Section 3 of the Mental Health Act (1983) [MHA] which enables a group of mental health practitioners to detain and treat mentally ill people in hospital against their wishes. Patients and Nearest Relatives have certain rights of appeal against these decisions.
Sec 136	A section of the MHA that facilitates police to detain people who cause public disturbance and who may be MI. Allows holding for 72 hours within which time arrangements need to be made for an assessment by a psychiatrist and an ASW
SMI	Severe and Enduring Mental Illness
SPR	Specialist Psychiatric Registrar – most senior medical training post in psychiatry, short of becoming a consultant
'Supporting People'	Local government commissioned system that provides a range of structured living environments for vulnerable adults. Offers varying degrees of support & independence, from minimal support in independent accommodation to some forms of hostel that provide less intensive care than a registered care home.
TAPS	Systematic study of the closure of the Friern and Claybury - large mental hospitals in the 80s - and evaluation of reprovion of their services in the community
'Tribunal'	Refers to the Mental Health Review Tribunal or First-tier Tribunal (Mental Health) [MHRT], which is the legal body responsible for reviewing the detention of SMI patients in hospitals. Has the power to discharge people who appeal.
Trust	In this context refers to an NHS Trust mental health service provider.
Wte	Whole time equivalent – a term used to measure staffing levels

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