Consultancy on Deregistration to a Care Home for the Long-stay Mentally Ill: You Can Take Stig Out of the Dump, But Can You Take the Dump out of Stig?

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Abstract

With the Olympic Games coming to London at the time of writing, summer 2012, and the country in economic crisis, the government is attempting to clean up the streets at the same time as cutting services by instructing mental illness to behave itself and meet mad targets. This leaves the mentally ill at most risk of being dumped. Following the dismantling over two decades ago of out-of-sight asylums, most care of the chronically mentally ill has been in registered care homes in the community. The legal definition of a care home is an establishment that provides accommodation with personal care, including assistance with bodily functions where required www.care-managementmatters.co.uk/documents/PeterGrose.pdf.

'Registration is a legal requirement under the Health and Social Care Act 2008 for all health and adult social care providers to register with the Care Quality Commission.' (forum.ukqcs.co.uk/home/forum/topic/36/8/1/17/)

However, in an attempt at reducing budgets, under the guise of cutting red tape and enhancing empowerment and independence, there is a proposal to deregister these housing associations by insisting that their customers become independent of the following needs: personal care, having their medication supervised, and having limited access to and responsibility for money. If a care home is deregistered then, in agreement with residents, the provision of residential accommodation, together with nursing or personal care, is discontinued, and instead these two elements are provided separately and tenancy agreements are put in place in the form of 'supported housing'. It is expected that the primary task of support workers will adapt to empowering the charges in 'their care' so that self-responsibility on the part of the mentally ill will increase. The difficulty is that the nature of mental illness would seem to make this impossible, which makes the demands themselves mad.

Key words: care, dump, personalisation, deregistration, projection, commissioners, containment, psychosocial.

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INTRODUCTION

Stig of the Dump is a modern classic children's novel by Clive King, published in 1963. It is an adventure story about a secure, adventurous boy, Barney, befriending a dislocated primitive caveman, Stig, who, deprived of his own people, language, community, and orientation of time and place, has made a creative adaptation of a rubbish dump. From the outset, there is mutual respect, creativity, and a non-verbal dialogue between the two, but the power imbalance changes as Barney finally enters Stig's world and feels like the outsider to a whole other universe with its own vigour and sophistication.

I present this story as a metaphor to explore the policies and provision for mentally ill patients in the UK National Health Service (NHS). The story was published during the 1960s at the same time as the then Minister for Health, Enoch Powell, made his 'Water Tower' speech, conveying his intention of 'nothing less than the elimination of by far the greater part of this country's mental hospitals as they stand today' (studymore.org.uk/xpowell.htm). The problem is, it seems likely that there may have been a fantasy of the abolition of mental illness accompanying the intention to eliminate mental hospitals. This may be manifested either through turning a 'blind eye' in care homes themselves, or through a 'gap in services'. This potentially leaves Stigs with no place to go, with their only option to make the best of being dumped.

This paper will consider the front line experience of not just 'care in the community' ('the policy of transferring responsibility for people in need from large, often isolated, state institutions to their relatives and local welfare agencies', www.dictionary.reference.com/browse/community+care), but give consideration to the wholesale shipment of the mental asylum back into society. A brief consultation was undertaken in an inner-city registered housing association, Horizon, that provides care to those who would in times past have found themselves in asylums; that is to say, the chronically mentally unwell, in this case, those who often have a history of both homelessness and mental illness.

This consultancy was undertaken on a pro bono basis as part of a postgraduate project. It was suggested by the manager of a community mental health team who was aware both of the availability of the consultant and a need in Horizon for a reflective space for staff, and the consultancy was then agreed to by the manager at Horizon.

I will start by outlining the socio-political context and then describe the consultancy. Thereafter, I will reflect and consider my understanding theoretically from systemic, psychoanalytic, and group perspectives. This understanding will be informed by my

own emotional antennae from experiencing countertransference phenomena and from associations I made to the projections and provocations I encountered. I will then conclude by linking the impact of political rhetoric to my experience of the distress and dysfunction at local level, and reflect on the possible societal impact of contemptuous decision-making.

HISTORICAL AND IDEOLOGICAL BACKGROUND

Life-long housing in asylums of those deemed sufficiently disturbed/disturbing to be locked up and kept out of sight, originally described as 'pauper lunatics', become the norm following the County Asylums Act in 1808 and Lunacy Act of 1845 (www.mind.org.uk, 18/8/11). In 1990, there was a radical overhaul of socio-psychological provision, under the new NHS and Community Care Act of Margaret Thatcher's government. However, in parallel, Thatcher herself had said in 1987, 'I think we have gone through a period when too many children and people have been given to understand, "I am homeless, the Government must house me!" and so they are casting their problems on society and who is society? There is no such thing!' (www.margaretthatcher.org/document/106689).

   The political landscape that expressed 'society? there's no such thing!' decided that, nevertheless, community was a phenomenon real enough to bear the relocation and care of the institutionalised or mentally unwell. Since this radical rethink, there has been plenty of planning concerning the objectives that care staff should implement for their customers, a term which seemed at odds with the needs of these individuals, who were mostly in no position to choose and purchase their own care. Over two decades later, this now translates into policies describing personalisation for patients and the movement towards deregistration for most currently registered housing provision. This is a philosophical continuation of Thatcher's stance 'there is no such thing as an entitlement unless someone has first met an obligation'. She expressed concern about impoverished, abused, or neglected children, but without an idea that they actually grow into adults who may have no concept of 'obligation' other than feeling owed for their lack (www.margaretthatcher.org/document/106689).

   But who must remedy this lack? The Thatcher government, and the current coalition government, impose targets as if the 'problems of human nature' were somehow forgotten. I am reminded of Charles Dickens' *Hard Times* (1854) which tells the tale of fact *vs.* fancy, 'facts alone are wanted in life. Plant nothing else, and root out everything else. You can only form the minds of reasoning animals upon Facts:

nothing else will ever be of service to them' (Dickens, 1854, p. 9). The link I am making in organisations is the wish not to look beneath the surface and to know about the unconscious (fancy) in residents and in the staff group too, whose evident struggle is their attempt to offer containment simply by keeping the focus on objectives (facts). The danger is that this then leads to staff burnout and either physical abandonment, with constant turnover of staff, or emotional absence and indifference. Deregistration means that issues of medication, money, and self-care will no longer be dealt with by those who are employed to provide supported housing, and so residents must be independent in these areas or be moved on. Somewhere else, there will continue, albeit an ever-shrinking, possibly contracted-out, registered care provision, most likely out of central London. This could result in an underhand return of invisible asylums. The difficulty is that customers who were taken originally from the Victorian mental institutions and placed in currently registered care homes think of this 'last-chance saloon' as their life-long home. Staff and residents alike have been living with this sense of an eternal 'organisation in the mind' (Armstrong, 2005), and this is currently under threat.

The idea that commissioners can simply instruct managers of housing associations to foster independence in residents who are often institutionalised is the real madness in the system. It is as if these long-stay patients suddenly are seen as customers with the ability to make choices in accordance with personalisation. In this paper, I will describe the impact of this shift in policy and the way it leaves not just residents in a stupor but staff demoralised, burnt out, and heading for the pub.

The dilemma for the consultant, in parallel with the conflict in staff when keyworking customers, is which defences to leave unchallenged. 'Keyworking is a system for providing individualised social care through named persons. A keyworker is the person who has responsibility and accountability for the care of the service user and for decisions relating to their situation' (www.socialcareassociation. co.uk/Portals/0/Public%20Docs/Keyworking%20in%20Social%20 Care.pdf). Evaluating whether defences had been erected by staff in order to enable them to cope was an important component of the consultancy, as overly exposing them to the impossible nature of their task could have been destructive.

Another area of difficulty integral to this work is touching the pockets of madness in oneself; which is likely to be both the underlying motivation for working with others who have been affected by breakdown, and concurrently the dread and fear of it. Bion (1970) writes of 'nameless dread', and Winnicott (1989) writes of 'unthink-

able agonies'. Eigen (1999) coined the phrase 'toxic nourishment', and explains that:

> Winnicott suggests . . . the breakdown feared already happened . . .. The infant's environment cannot protect it from overstrain, and the person carries the imprint of being broken in infancy . . . while the personality was beginning to form, a time too early to organize, hold and experience, what was or was not happening. As one grows, defences organize around this point of madness which one sometimes glimpses in disorganizing moments. (Eigen, 1999, pp. 171–172)

The nature of the work with severely mentally unwell residents is potentially full of 'disorganising moments'. Organisations tasked with accommodating 'unhoused minds' (Scanlon & Adlam, 2008, p. 529) often have their own ghosts, which can include drug misuse and deaths resulting from overdoses, which can traumatise employees and leave them with professional scars.

Organisational consultancy may at least offer a way to consider the systemic problems that culminate from a toxic mixture of political rhetoric, lack of investment, simplistic and dangerous misunderstanding of mental ill-health, and a system-wide contemptuous attitude towards those who do not contribute to glowing statistics. The work of consultancy may be to make contact with this mess, and tolerate the fear that one could become subsumed by it. To really make contact with the reality of community care, it is necessary to get close enough to the experience of staff and residents at registered care homes without over-identifying with their visceral life-and-death struggle in a last-ditch attempt to enable functionality, or to stay too far away by attempting to be invincible by arrogant attempts at rescue.

There can be a feeling that the life has been sucked out of care homes, and sometimes there is an acknowledged wish to develop potential; for example, setting up horticulture in a disused garden. Metaphors may abound with regard to a wish for a nurturing, enabling environment rather than warehousing (Miller & Gwynne, 1972). Nevertheless, management, after all, have to speak the commissioners' language and play their game, while managing staff at the frontline doing what is possible, and all the while living with the tension this creates. Commissioners are funded by a government divorced from the experience 'on the street' (Cooper, 2010).

THE CONSULTATION

The manager of the local community mental health team oversaw the mental health treatment of the residents and knew that there

was a high rate of staff turnover and a new manager in place at Horizon. Aware of the possibility of a pro bono brief consultation, she informed Horizon's manager and he agreed to meet with the consultant. He decided to go ahead with the consultancy 'because we need it and it's free', and invited the consultant to a team meeting with staff at which were agreed the times and dates of eight regular, reflective staff group one-and-a-half-hour weekly sessions.

To maintain confidentiality and yet to give a flavour sufficiently close to the experience, I will attempt to give some generalised details from the setting, with identity of the organisation and individuals changed. In this paper, I will refer to the story *Stig of the Dump* and give one of the residents the name 'Stig'. I did not use this metaphor during the consultation sessions with staff; it was an idea that evolved through my own reflections afterwards. This not only maintains confidentiality but adds a societal metaphor for those who are seen as 'down and out' and living on the edge of community life. I use this as a mechanism to consider the assumptions that are made about those who live in this way, as if it is they who are unsophisticated, inept individuals when, in fact, they provide a social commentary on the housed, the secure, and on those who have made apparently sophisticated decisions about registered care. This metaphor is therefore a challenge to the assumptions of normality and a reminder of the danger of treating inappropriately people with such needs.

The main thrust of this consultancy initially was to consider the impact that pending deregistration was having on staff and residents. Staff explained that the idea of those residents who are institutionalised becoming completely responsible for their own medication, toileting and hygiene, and rent just did not seem feasible. Staff confirmed that many of the long-stay residents behave as if in hospital and describe staff as 'nurse', even though no staff are medically trained. In parallel, a few staff themselves seemed somewhat institutionalised and resistant, while others were responsive to the consultation.

In the sections that follow, I will describe the events and conversations that took place at the meetings at Horizon, and my reactions and thoughts about these, as they occurred.

First impressions

As I was leaving a setting-up session, one of the residents arrived back from a shopping trip dragging bags, and called out to some

younger male residents for help, as she strained her head, smeared with red lipstick. They ignored her and she grunted. This patient, whose name was Maggie, would reappear from time to time on my visits to Horizon, and I considered the metaphor that she represented; was I to be ignored, helped, seen as useless? In contrast, Ann, with her shaven head, simply sat staring in reception and barely seemed to move. I wondered about the impenetrability and intransigent nature of organisational difficulties.

A week later, I attended a staff meeting and met the team. I felt fearful of making a mess, perhaps like clients who soil themselves with anxiety. I could sense the powerful projections ripe for being identified with! Maggie was leaving as I arrived and, although she did look dishevelled and eccentric with her vivid, garish lips, she was nevertheless braving the outside world. I discovered there were many temporary and agency staff; it was the residents who were mostly 'stable' in their immovability. That is, until now, when moving them on suddenly became a political imperative. The danger seems to be that complex decisions that should be based on human need are instead based on misconstrued financial restraint and political rhetoric, and are urgently imposed.

Meeting the team

In stark contrast with reception, where the resident Ann seemed in catatonic stillness, there was high energy inside the staff room. I explained to the staff that I am an organisational consultant and that I had agreed with management to offer eight sessions with a cross-section of changing staff to consider the impact of deregistration. Management interjected support and suggested that a core group of regular attendees would be useful. I then explained that I would not be offering clinical supervision; in other words, that I would not be focussing on individual patients' diagnoses, medication, or clinical presentations, but rather on staff dynamics in the team and what it is like to work here in the face of deregistration and change.

A support worker replied, 'like some kind of horror movie where it hangs over you somewhere in the distance'. He gestured a threatening, gripping hand in my direction. There was laughter amongst the team and a murmur of agreement. I offered an interpretation that this was perhaps an indication that they would be showing me how violent the struggle is and letting me know how threatening and horrific it can feel, but also that there is a feeling of being in the grip of something.

Session 1

I wondered how working in a modern-day community asylum might impact on staff. The struggle of getting in continued throughout the consultancy, somehow there was an obstreperous gatekeeper both to the physical building, but also the organisational psyche. There were painstaking efforts in evidence to help a resident with her payment of expenses in pounds and pence; a way of training residents to be ready for deregistration.

I wondered what the residents made of my presence. Somehow, even if unconsciously, they nominated one of their group as their visitor to the staff consultancy. In this written description, I will refer to him as 'Stig', and he will represent the resident group in the account that follows. Stig is at real risk of being rubbished or ending up in the rubbish dump – but there is more to be considered about what he represents than assuming he is simply a passive individual recipient of services. 'Stig' in the story is more than just a caveman living in a dump – he shows his morality, integrity, and complexity when he has the chance and helps save society from its thieves.

I introduced myself to the ten attendees at the meeting and described my function, 'to provide a reflective space to bring thoughts and feelings about organisational changes, for example, deregistration'.

A hope was conveyed that deregistration would become an activating force which would motivate staff as well as residents. However, this was countered by despair, as it was perceived that there were many more residents who were long-stay inpatients, institutionalised, and of retirement age, unable to become independent, than had been suggested. To account for this difference in attitudes, I suggested of this long-stay group 'perhaps they seem to occupy a large space in your minds, and perhaps at times they look older due to such tough lives'.

Anxiety was expressed by staff about being responsible for such vulnerable adults and a fear of being held accountable if something went wrong. However, this brought memories of residents being badly affected by the idea of deregistration and the panic that had been felt by staff, relatives, and residents about the prospect of residents losing their home, in some cases after seventeen years there. A letter had been provided by senior management that staff were instructed to send out to all residents and their relatives conveying the idea of deregistration taking place at the end of the same month. Staff described worried relatives phoning up for hours and how

awful it was. Staff appeared to feel let down and angry that they had had to carry this trauma and threat – and then it had not even happened! There was also a sense in which they felt they had managed without a manager or a consultant then, and so the timing of the sessions now was wrong; too little, too late, perhaps.

Fears were then voiced about job security, and others bemoaned poor pay and dispensability. Management responded that, in theory, in the current era, although unlikely, another organisation could make a bid and take-over provision, but funding should continue until 2013. At this point, I was aware of my responsibility not to offer an 'alarming letter' that would threaten their professional homes; in other words, to be respectful of their social defences (Menzies, 1960) – which may mean being mostly in denial about short-termist political planning for long-term patient needs!

The splits in the group were already becoming apparent – anxiety *vs.* nonchalance; abandonment *vs.* stickability; fear *vs.* high hopes of deregistration. One support worker dared to say how boring she found the work, and she hoped deregistration would change this.

Session 2

A support worker would say during this session that one of the residents would tell her he did not like her culture, rather than the colour of her black skin, and would often look past her. I asked what it felt like to have that kind of experience, and she said she does not let it bother her: 'if you let things like that bother you, you're in the wrong job'. I thought about Winnicott's (1958) 'Hate in the counter-transference'. Most staff keep moving on, and I had a stream of new faces attending the sessions throughout, even the final one. There were eight attendees in this session.

At a strategic level, the most shocking idea was communicated – that three out of five registered care homes in the locality were being deregistered, not including Horizon. Residents judged to have high support needs that could not be accommodated after deregistration in Horizon would probably be moved out of the borough into care that would be more like a locked ward, with even less scope for independence.

Concern about management of medication was raised, in particular the risk arising in some cases because it was such a challenge to keep track of all residents when they each had different needs and levels of responsibility for their prescriptions and medication. Throughout the consultancy, there was a huge emphasis on the onerous nature of medication, and a hope of freedom following

deregistration when they would no longer have responsibility for it as an organisation.

There was a theme of 'difference' amongst the attendees in this session, both in terms of medication and also breakfast options, which could be chosen by residents and to a greater or lesser extent facilitated by staff. Some staff spoke proudly of their ability to foster independence in residents. Collective meals were described as the most stark reminder that they are in an institution, as nobody really spoke and there was nothing much for staff to do apart from clearing up at the end. I asked whether they could feel a bit redundant. I offered an interpretation that, 'perhaps your function as staff on these occasions is to show residents that indeed this is an institution – it offers containment and perhaps, in some ways, it's important both for residents to develop independence if that's possible and maybe at times for there to be a social situation such as a shared meal'.

Following the previous session, full of descriptions of agitated staff and residents struggling with deregistration, the general atti- tude to this sea change was different today. There was agreement that the idea of moving towards deregistration now, before it was even implemented, was motivating staff to empower residents towards independence. It sounded as though they felt guilty for their previous complaints, and so today compensated with rhetoric or positive clichés, which in fantasy might satisfy commissioners. However, it was recognised that residents who had been institu- tionalised for seventeen years, 'are going to need time and it's baby steps'. A new member of staff proudly used the term 'customer'. Others retorted that they were rebels here at this particular project and say 'residents'. The rest of the staff chuckled.

There was a regular theme: having a party or going to the pub – perhaps to stimulate life, communicating a sense of celebration or connection, but also drowning sorrows, or breaking down bound- aries, something that could feel exciting or dangerous.

Session 3

Continuing this theme, allusions were made in this next session to raucous behaviour by staff when off duty, for example in the pub, by the nine attendees. The main thrust seemed to be that most of the liveliness was somewhere other than in work with the residents, which seemed deflating. Armstrong (2005, p. 81) proposes that, 'every organisation contains a pathological version of itself (a shadow side) . . . to serve as a psychic retreat when the internal or external situation of the organisation threatens the limits of its

capacity'. Perhaps, to manage the assaults directed to the organisation by government directives and to cope with the persecutory demands from residents, 'mobilisation of the pathological version, as a latent system within the organisation' had become chronic and, although it did 'not prevent working from getting done, . . . it interfered . . . through robbing it of vitality and meaning' (Armstrong, 2005, pp. 81–82).

There was an organisational myth emerging towards deregistration: it would be a cure for ills not only in residents, but would remedy staff complaints of stress and boredom too. The shortcomings of personal care were described, along with complaints about the old-fashioned attitude of psychiatry. There was the idea that residents are unwilling/unable to tow an imposed, apparently meaningless objective, in terms of the government directives, which were perceived as irrelevant and possibly causing staff to leave, go absent, or feel undermined.

Suddenly, there issued forth an outburst describing a feeling of boredom with discussing deregistration. After which, concerns about staff turnaround and low pay were disclosed. One redeeming comment:

> I think the way to keep the job interesting is to focus on individuals because they are endlessly interesting. Although personally, I think that's where personalisation might clash with what somebody actually needs due to their mental health capacity . . . commissioners come and go . . . focus on the residents.

Session 4: naming Stig

The eight attendees to this session raised questions about how to manage the routine demands of the work and daily rituals, the possibilities of difference amongst staff and residents, and at the same time managing risk. At times, we had gallows humour, and other times, more of a party mood. Then the tick-box issues of health and safety were bemoaned.

However, it seemed almost impossible to pause and get hold of concern. I thought it was important to acknowledge our weekly visitor, as he seemed significant, and I wondered what he was bringing to the group to think about:

> *Consultant*: Is it Stug who comes and does his check on us every week?

> *Chorus*: No, Stig.

Support worker: Well, there aren't so many staff downstairs so he's come to check where we are. Then he'll feel OK.

Consultant: So the health and safety of the place is very important to particularly anxious or paranoid residents?

The level of institutionalisation and difficulty taking in any nutrition from human interaction became apparent: 'small, round tables with table cloths and plastic plants have been trialled, but the residents didn't like it at all, so old, long, impersonal tables were brought back', said one key-worker sadly.

However, in facing these challenges of boredom, risk, and institutionalisation, perhaps the group of attendees was beginning to think together, and I noticed a 'chorus voice' and wondered whether this was a sign of a working group emerging. Aggression was openly expressed by one of the two team leaders; a request was made for a punch-bag for staff; initiatives being thwarted amongst staff were discussed; and a wish expressed for there to be more competitiveness.

Session 5

There were two pairs in this session in the staff group – a nonchalant pair, and a couple concerned about risk of violence. The manager showed commitment through attendance, as usual. I wondered if perhaps the team were in a permanent state of fear of resident madness and/or violence, staff burn-out or resignation, and/or commissioner expectation. I felt superfluous and disconnected, as if staff simply go through the motions of duty, and consultancy was another empty task that they had to drag their bodies through. I wondered about the reduction in attendees to five, and whether my previous confrontation of staff with their own boredom had felt to them like an attack.

Nevertheless, a crucial issue of risk started to become manifest from this session onwards, as if there had been a turning point in the consultancy. Perhaps sufficient trust had been established to enable a real exchange. The issue of risk posed by customers and whether female workers should be accompanied at times was raised. Some discussion followed about residents signing, or refusing to sign, their risk assessment, which may be an indication, suggested the manager, of 'how much or not they concur and engage with the reality or the way it's perceived'; or 'may indicate their relationship to the institution', I added. A description of recent resident violence to staff and the lack of safety bleepers or walkie-talkies and staff

resorting to using their personal mobiles at work was mentioned, and I raised the possibility that 'staff can become institutionalised and switch off to their own sensitivity which might alert them to concern, which is actually worth paying attention to. Managing anxiety is also necessary, or else the system may provoke a denial through turning a blind eye to risk'.

However, when I tried to link the strain of managing anxiety with people leaving their posts, this was denied, and a suggestion made that people mostly leave as a result of promotion, not burn-out at all! It seemed to me that as soon as we got hold of something as a group, it was too slippery and difficult to focus; as if by talking about concerns, all staff would leave. The strain of weekend shifts and lack of weekend staff was also stressed.

Progress in terms of the work with residents was described as making arrangements for them to go on a trip to the seaside and to hold a sports day.

Session 6

This time, instead of Stig visiting the session in person, he was thought about and considered by the group of six attendees. The session started with more fantasies of greater freedom and flexibility and less responsibility, and time being taken up with medication post-deregistration. The session continued along the lines of the arduous nature of the work: from trying to teach resistant residents how to use the washing machine, to managing others who decline the psychiatrist's suggestion of managing their own medication, to lack of take-up of a visiting optician. A disappointing turnout for the seaside was described, with only three residents taking up the trip, but there was immense pride and satisfaction, and evident emotion, about how Ann, who rarely goes out, made the effort worthwhile as she was excited and loved their outing. This perhaps suggested mobilisation of 'stuckness' in the organisation.

The crux of the consultancy: Stig of the dump

Almost an hour had passed when two support workers entered; they gave the impression of having a deliberate plan. Finally, the crux of the consultancy manifested.

But what about Stig? I mean his flat is really dirty and he's got two fridges full of newspapers and things he's picked up from the street.

He used to be street homeless didn't he?

Why has he got two fridges?

Yes, he lived on the streets. But he doesn't like you cleaning his flat, he's not comfortable when it's clean. But I think, what if an inspector came and saw the state of it.

But it was cleaned last week.

Well, then it's dirty again.

But no, you can't accumulate thick dust like that on the skirting board and the TV in a few days. Perhaps we need to think more about cleaning. That flat needs a really deep clean.

Consultant: But what you're saying is that it's the dirt and the smell of it that makes him feel at home and he's living like that, here in registered care with an idea of making him more independent. He's showing the state of his mind and he's not very well. That's the reality you're faced with in terms of some of these residents who have been here since before 1995.

That's what's so difficult.

Mmm, it is.

There was a feeling of a full session, and not wanting to end. There was a poignant, heartfelt moment when the reality of the work was powerfully communicated. The perpetual question seemed to be, 'You can take Stig, and those like him, out of the dump, but can you take the dump, his disturbance and others' projections, out of Stig?'

I was left preoccupied with issues of neglect of duty of care, from the organisation towards staff and from staff to the residents. I was also in a quandary about personalisation: 'choice and control to those who receive services' (Cooper, 2010). If taken too far, this can lead to Stig recreating his dump and being left to it, which is a perpetual health hazard. When concern was raised about an inspector seeing the filth, at that moment I was being seen like the outside observer bearing witness to the shame.

Session 7

Staff described this session as organisational therapy, as opposed to 'supervision', which had been the inaccurate descriptor at the outset. There was a theme of viruses, treatments for them, and whether antibiotics are effective. I felt that this was a dialogue amongst the

seven attendees about what kind of 'medication' could help them with the 'infections' in their work; perhaps something ongoing would help rather than one dramatic gesture. Some difficulty was expressed about trying to enforce progress in preparation for deregistration, thereby making residents worse, for example, inducing panic attacks.

The attendees were thoughtful and pointed out the painful reality for some residents, and how, if this becomes intolerable, retreat or regression can follow, and then there's the grey area between what commissioners expect and demand, and what people can actually manage.

Session 8: last session and review

Unusually easy access into the building caused me to note the contrast from trying to enter a fortress on my early visits to almost an open house now. There were four attendees to this last consultancy session. They started discussing success stories and celebratory parties and creative, progressive residents in some of the other projects. Management was on leave and therefore absent from the consultancy for the last two weeks, 'felt not only to be contemptuous of the group, but also to be expressing that contempt in action' (Bion, 1961, p. 49).

However, there was a willingness to have a meaningful dialogue and consider residents and staff interactions in a reflective way. I was particularly encouraged as there was a willingness to think, and also an acknowledgement of the possibility of professional burn-out resulting from a mismanagement of boundaries in a wish to be overly helpful. This enabled a frank dialogue about successes and difficulties, satisfaction and frustration. I had hopes that the attendees to this final consultancy session could form a creative core to support the larger system. There was also an acknowledgement of the loss of the consultancy: 'I'm disappointed it's coming to an end, really. It's the only project I've worked in where there's been this kind of space, and I think it's valuable'.

Disappointment was conveyed about the lack of investment in staff, frustration about lack of development, and dismay at the lack of recognition of the stress of the job. They all expressed as a joke the fear of ending up in the currently empty flat at the home and becoming a resident themselves, which was a significant recognition. Some satisfaction was expressed about the progress of some clients, who could now have a civil conversation.

Then came the final word from Stig, who defiantly put his head around the door and blew cigarette smoke into the consultancy

session. As I left, stubborn Stig was sitting in reception looking self-satisfied and triumphant, as if he was blowing in the face of authority, 'You can take Stig out of the dump, but you can't take the dump out of Stig'.

AFTERTHOUGHTS AND REFLECTIONS

I came to realise the primitive, visceral needs of residents and the taxing nature of the work. Swinburne (2000, p. 223) describes in his paper 'Home is where the hate is':

> borderline and schizophrenic individuals . . . tend to make up the bulk of residents within community mental homes [and] function in a manner akin to that of the early infant prior to the development of internal space via the introjected experience of a containing maternal object relationship . . . as a consequence of this the challenge facing staff working in such environments becomes one of replicating maternal containment as the prerequisite to therapeutic aspirations or notions of meaningful change within their client group.

In retrospect, I can see that the consultancy sessions may at times have felt like the weekend work that staff were wishing to get out of and management had the worry of trying to staff. In this way, it's possible to see that the transference directed towards me as the consultant is of a bad, demanding object that expects thinking, making links, and communicating. But actually, when thinking did take place, some very violent thoughts and images were brought to mind, and so there was an avoidance, 'a taking leave' from the mind. There was a risk of becoming indifferent, lapsing on the duty of care, or even losing 'being human' and becoming robotic.

This led me to consider the following hypothesis: because the reality of the challenges in the work are overwhelming, there is a way of turning a 'blind eye' to difficulty / complexity / suffering and a wish not to think or feel. This may lead to an apparent nonchalant / robotic attitude, with a lack of safety devices in place to manage risk; a wish not to see danger and tokenistic records, on one side, and at other times a feeling of being flooded by overwhelming demands that may lead to despondency and a feeling that there is little possibility of making an impact or having efforts recognised. This is likely to lead to 'asylum annexes' in which individual residents and staff feel in a mad world and left alone to confront their isolation, anxiety, and decline in a macho culture.

This is the risk of 'asylum in the community': that there is an illusion that rather than being an institution providing care to the most

chronically mentally unwell, there is a fantasy of a rehabilitation centre to empower independence and enable moving on. This can cause a 'dump' into those members of staff who allow themselves to see the primitive functioning of the long-stay residents, the 'Stig', but who then themselves are pathologised for what they draw attention to. Eventually, this 'dump' gets re-projected into Stig, who recreates a physical 'dump' and becomes the receptacle for 'rubbish' in the organisation.

The issue of reparenting

The general difficulty with many residents is lack of self-awareness in order to differentiate their individuality, so that becoming more 'independent' is a far-off milestone. To help clarify this from a theoretical perspective, we can consider Mahler, Pine, and Bergman's (1975) and Winnicott's understandings of infant development. His 'majesty the baby' (Winnicott, 1965) is at the 'autistic phase' (Mahler, Pine, & Bergman, 1975), which is the auto-erotic stage in life during which self-absorption is so intense as to disallow recognition of the mother as a separate being. He matures through 'the psychological birth of the human infant' (Mahler, Pine, & Bergman, 1975), an accomplishment enabled some months later following attuned nurture, if the skin and mind boundaries of the care-giver and baby can be recognised by both as separate. Winnicott draws our attention to 'there is no such thing as a mother without a baby' and vice versa, and in the end 'good-enough parenting' is desirable – over-indulgence or neglect both result in difficulties, hence his book title, *The Maturational Processes and the Facilitating Environment*.

   Similarly, keyworkers and their resident clients have a reciprocal relationship. Some of the residents, it would seem from the descriptions given and appearances made, have not re-emerged as identifiable individuals with their own body/mind boundary. This may be exacerbated by staff needs for closeness and merger – needing to be needed – or conversely, a fear of getting too close to the madness in their charges and therefore keeping distant and becoming neglectful. This leads to the split of warehousing *vs.* horticultural (Miller & Gwynne, 1972) attitudes in staff, who on the one side may feel overwhelmed and therefore emotionally absent from their roles, or, on the other, struggle to regulate the closeness. Research exploring the social model of disability has produced substantial evidence that social attitudes to disability have a serious and damaging effect on the quality of services and resources made available to disabled people and their families. Cooke (2000) highlighted how the endemic

marginalisation of disabled people promotes the acceptance of a lower standard of care for them, and is one of many researchers promoting the 'social model' of disability, referring not to impairments but to social barriers (Paul & Cawson, 2002, pp. 262–281).

Thinking systemically, this is encapsulated succinctly by Foster's description (1992, p. 1), 'to give a person the care that they need can be institutionalising in the manner that it is done ... [after all] ... it is not bricks and mortar that define an institution but the manner in which an organisation behaves towards the bodies in its care'. Miller and Gwynne (1972) describe a concept for good community care which seems eternally applicable in a multitude of settings. They define it as a system that is able to meet the needs for both psycho-physical dependence and independence concurrently, and crucially a support system to monitor the two in terms of how they operate together and how the balance needs to be dynamic in response to client/resident ability. However, in considering the unconscious motivation for social barriers, or indeed team dysfunction, Bion (1961, p. 39) explains that, 'the group ... is charged with emotions which exert a powerful, and frequently unobserved, influence on the individual. As a result, his emotions are stirred to the detriment of his judgement'. If basic assumption one-ness is operational, then:

> Through this defence, team members avoid struggling with differences by behaving as if everyone in the team were the same. This is a flight from true multi-disciplinary working resulting in staff functioning at the lowest common denominator of sameness, giving up the satisfaction which comes from professional expertise in favour of team cosiness. This defence obscures the value of difference and drastically reduces the options available to the client. (Foster, 2010, p. 3)

However, the further danger is that if staff are unable to appreciate and use difference within their team, they may also turn a 'blind eye' (Steiner, 1993) to differences in the client group and treat them with a panacea of 'same treatment' no matter their level of functioning. It follows that this then further induces dependency and institutionalisation within residents, and a vicious circle is set up between the two groups: a staff group impaired by basic assumption one-ness treating with indifference and lack of creativity a resident group in basic assumption dependency, expecting to be looked after. Through this deconstruction, we start to get a systemic picture of despair. Bion (1961, p. 48) acknowledges, 'a group whose members cannot attend regularly must be apathetic and indifferent to the sufferings of the individual patient'.

However, this is not the full picture, as there are also signs that basic assumption me-ness was in operation: 'a case of everybody does their own thing with residents as if they were all the boss whereas what they need to do is to wait for the actual key worker, who knows the resident best, to share their view first and then make a decision together not on his own. But we don't always do that around here'. Hatcher Cano (1998, p. 84) captures this theoretically:

> Me-ness group members defensively collude with 'the assumption that there is no group at all – just unaffiliated individuals, whose only joint purpose will be to thwart the formation of a group out of fear that they might be submerged in it or persecuted by it if it did form.

In this case, the staff often acted in a disparate manner akin to parents who are not a united couple and can be individually drawn in to favouritism towards the uncontained, paranoid resident 'children'. It is possible that their mental health will deteriorate in a chaotic system which does not hold individual residents in a reliable, consistent organisational mind. I thought about the need for some mothers to emphasise their ability to care due to their own infantile needs, and the parallel with staff who may feel insecure and demonstrate their effectiveness in a misguided way by automatically doing things for residents without assessing whether this is appropriate. This may foster dependency and cause deterioration of function, and the cumulative effect over time is institutionalisation. At the other end of the spectrum, premature demands for independence do not enable a secure base within individuals, and the threat of losing one's 'home' can cause destabilisation, decline, and a desperate clinging. Subtle attunement to physical capability and emotional readiness are key in this work in rehabilitating residents, just as with 'rapprochement' (Mahler, Pine, & Bergman, 1975) with toddlers finding their first steps, exploring the world, and then returning to the secure base, and with adolescents/young adults leaving home and coming back metaphorically or literally with dirty linen. In some ways, whenever we are confronted with change, we revisit, emotionally, these early formative stages, and if they have been traumatic, we will find navigation through relationships, job changes, different life stages such as mid-life and ageing, much more traumatic. For some residents, this is the cycle they are stuck in, and from which they may never emerge due to the extent of their historical and present difficulties; it is as if they are still weaning, or refusing to become weaned.

However, the nature of the residents' mental illness not only 'leads to the dynamics of institutionalisation . . . [whereby] . . . home is constantly under attack from the unconscious process of the resident group' (Swinburne, 2000, p. 224), but, in my experience, also to 'asylums in the mind' in staff who withdraw and vegetate or flee from a capacity to think individually or collectively. This may happen through the mechanism of projective identification whereby the physically and mentally broken-down state of individual residents gets not just under the skin of the organisational body and assaults the physical integrity of the 'care home', but additionally, perhaps, penetrates the nervous and digestive systems of staff, leading ultimately to burn-out or abandonment.

My second hypothesis is that shame can get a grip of the staff as a result of identifying with the governmental expectation of transforming the residents from needing the kind of care provided by a registered home into more functional people who can have their needs met in a deregistered care home. Residents such as Stig who do not manage this represent for the staff the evidence of having failed in the task so defined.

Stig was the only resident to come and visit the consultancy, and for all but one session. He was central and showed me the living essence of organisational difficulties, and perhaps challenged the consultancy not to forget him. However, like a troubled child displaying familial strife, holding Stig in mind seemed too painful, and so he had been left like a 'Stig of the dump' to rot in his own filth. After this revelation, there was a clear demonstration, by management particularly, of a need to 'forget' about him and the work with me, by avoiding the subsequent consultancy sessions, as thinking and linking meant being confronted with a failure too difficult or painful to face. In their minds, as an authority figure, I may have been partially identified with the persecuting policy-maker, while Stig may have been seen as a saboteur to meeting their targets. I made an attempt to help free them of their shame by helping them see that it is the expectation that is unrealistic – you can take 'Stig out of the dump, but you can't take the dump out of Stig'. However, staff do nonetheless have to work within a system that requires in one sense that they have to play the game of appearing to enable people to 'get better' and yet be confronted by each resident's pathology, resistance, and insistence on finding their own level – which may include filling a fridge with dirt and newspapers from the street.

In being challenged with Stig, staff, and anyone who cares to observe closely enough, are confronted with an aspect of human

nature that is destructive and despairing by which the death drive triumphs (Freud, 1901b) in a purgatorial perpetuity. For staff, whose internal motivation for doing the work is likely to be to make internal reparation (Klein, 1959) for unconscious infantile destructive phantasies, they are thwarted by the impossibility of the task and confronted with a double dose of shame. The shame comprises of the original trauma to their own psyche and then again in the breakdown in attempts at reparation by a failure of the primary task. The staff's own needs for containment mostly go unmet, and just like a mother who tries to apply a baby manual for care but is unavailable to spontaneously attune to different expressions in her infant, due to either aspects of her own mental health being impaired or her current environment lacking support, so staff may become indifferent to, or at worst neglectful of, residents who cannot perform the required milestones that cause them, in turn, to fail the latest standards of housing and care. This may conveniently deposit feelings of failure and shame into staff, and these are then defended against through turning a 'blind eye' or manic activity. This may evoke retaliation, withdrawal, breakdown, despondency, or manic defence, and/or an attempt to dump this multitude of disturbing feelings, including feeling useless, back into residents or into a visiting consultant.

I wondered many times whether I could make a difference and compensated by perhaps over-linking and thinking. Misplaced overemphasis or apathy seemed to be a general feature in this work, and we could see this in relation to risk, which Foster (1998, p. 84) describes succinctly:

> paternalism and over-protectiveness are characteristics of the risk minimization position evident in policies . . . which if we are not careful may lead to unnecessary restrictions being placed on the liberty of those identified as being a risk to others and to themselves. This in turn limits the possibility of integrating the mentally ill in their communities. We have to find a middle road between being over-cautious by unnecessarily limiting our own and our clients' experiences, and being cavalier by putting ourselves and others in too much danger.

Barney's grandmother in *Stig of the Dump* seemed to enable just the balance – sufficient nurture and protection, and yet space for adventure and imagination. It is this combination of 'fact *and* fancy' (King, 1963) that is so qualitatively different from the 'fact *versus* fancy' of *Hard Times* (Dickens, 1854).

CONCLUSION

In this consultation, staff members were able to bring fears and concerns that seemed to have been festering and sapping creativity from the staff group. Whether this was sufficient an experience for it to have been internalised by the organisation for its healthier functioning remains to be seen. Foster (1998, p. 85) summarises the core issue:

> an unspoken but powerful expectation is placed on professionals whose job it is to care for the mentally ill in the community: that they will make mental illness disappear, either by curing the clients or by making them invisible. . . . the real task of professionals in mental health work is to do what highly anxious and disturbed people, communities or systems cannot do: that is, to think while keeping in mind the disturbing and conflicting aspects of the situation.

As consultant, I am left, as so often are staff working with those with mental illness, not knowing whether I have made a difference. While my own narcissism certainly was not indulged, as there was no recognition of my input by management, it seems that important reflections were brought to consciousness and shared, and some necessary understanding and realisations developed. With the final four attending the last consultancy session, the two team leaders and two committed support workers, I was left hopeful that a reflective core might continue. It seems that the team present for the last session could acknowledge the value in having a reasonably undistorted mirror that reflected back. This means that they were demonstrating a capacity to emerge from the organisational psychotic 'hall of mirrors'. My hope is that there will be less avoidance of clients, less hiding in the staff office, and that some of the vitality that staff members currently access in manic defence via the pub and the staff room can become more widely available. Ideally, more effective systems of care need to be engendered by communicating staff concerns with a thinking organisational mind, contained in a reflective team within a building that provides a home for minds as well as bodies. I am aware of the challenge this presents due to the 'fear of breakdown', as conceptualised by Winnicott, and the use of social defences, as described by Menzies (1960), to defend the workgroup against the anxiety emoted by madness, not only in residents, but in the political climate. We can usefully consider Winnicott's conceptualisation of the personal from an organisational perspective:

in the simplest possible case there was therefore a split second in which the threat of madness was experienced, but anxiety at this level is unthinkable. Its intensity is beyond description and new defences are organised immediately so that in fact madness was not experienced. (Eigen (1999, p. 172), who quotes Winnicott (1989, p. 127))

The question would be what structural containment can there possibly be in a political climate in which professional survival is insecure and the validity and necessity of the work is being attacked. Foster (1992, p. 6) hypothesises that:

workers in the field of community care need to feel adequately contained themselves in order to provide effective containment for their clients. . . . Can we as workers in community care provide adequate containment for the projections of our clients and of other workers in the field and struggle to think about our own tendencies to project and enact before acting or are we, given the extreme anxieties that the demands of the job can stir up in us, liable to respond like the uncontaining mother.

There is a risk that dysfunctional silos will develop within the organisation, and the asylum, an actual building before 1990, then retreats as a virtual pocket in staff minds, leaving organisational, group, and individual madness uncontained beneath the radar. For some staff, this will be reminiscent of Winnicott's 'breakdown', described earlier in this paper, hence high staff turnover. Perhaps we can all try to avoid either metaphorically joining in with Stig by getting down in the dumps or fleeing in an attempt to abandon what he represents inside ourselves.

I would like to end by turning back to the socio-political and wider implications. Foster (1998, p. 85) poignantly describes how primitive responses towards those with mental illness demonstrated 'mental disturbance within our society'. Ultimately, residents pay the price; Foster (1992, p. 7) describes the risk:

without adequate containment creative thought becomes impossible and madness or disturbance is put out of mind. We can project all of this into those labelled mentally ill but we can no longer conveniently put them out of sight. Instead we see the casualties of this process on our streets.

So while the Olympic Games is a test of stamina, fitness, and agility, the wellbeing of services is under threat with a danger of a growing split in society between the fit and the unwell; an undesirable outcome for all. The risk is that the Stigs of our communities will create their dirty dumps either in care homes through neglect or on

the streets as they are deliberately or inadvertently dumped back outside as undesirable. However, society has demonstrated its outrage towards wealth imbalance through summer riots in 2011 in England and anti-capitalist demonstrations internationally, and so perhaps some of the projections into Stig and his dump can, over time, be reabsorbed. However, as a cautionary note, in one of their adventures, Barney and Stig manage to prevent thieves masquerading as TV repairmen from making off with Barney's Granny's silver when Stig 'let out a sound that was something between a growl and a howl and dashed at the man, raising his horrible club' (King, 1963, p. 88). We should be wary of stealing resources and imagining there will be no price to pay.

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