Showing respect for dependency – a Tavistock approach to systems of care.

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It is no coincidence that the Tavistock Institute and the NHS are both celebrating 60 years at this time. The Institute needed a separate identity from the Tavistock Clinic, when the Clinic went into the NHS at its inception in 1947. So it is a good opportunity to ask how Tavistock thinking about organisation continues to be relevant to the NHS at this time.

I want to focus on one issue among many – while not forgetting the wider context explored by the recent Wanless Report, concerning value for money and productivity, the issues about investment and PFI funding, and the political agenda to do with a national health service. A systems psychodynamic approach is just that – it draws on psychological insights into human relations at work but not in denial of or removed from the realities of developing and managing a hugely complex service industry.

The one issue I want to address is itself complex and far-reaching in its impact. I want to give it some air, because it is in danger of being suffocated in a post-welfare culture of opportunity and choice, conflating the differences between a corporate business and a public service. I want to think about dependency in human relations, and make the case that there is an appropriate dependency that has to be addressed and not avoided, if we are also to expect the agenda of opportunity to be successful.

Thinking about dependency.

It is surprisingly difficult to be neutral about the concept of dependency, to accept that dependency is a fact of life, from our first breath to our last. The collected papers of Eric Miller, the distinguished social scientist at the Tavistock Institute from 1955 to 2002, has the title: From Dependency to Autonomy. This implies some sort of progress, I suggest, actually or at least wished for. An immature dependency, where we put aside our own competences in order to look for gratification of our needs in the competences of others is pathological, so that a welfare state is described in derogatory terms as a nanny state, maintaining people in infantile dependence rather than encouraging an appropriate reliance on one’s own capacities to cope.

I want to make an argument for the recognition and respect for an appropriate dependency, in particular in relation to services for people who are vulnerable in our society. In this context I worked with Eric Miller on action research projects to do with disability, and also the care of older people, and with Isabel Menzies Lyth on the needs of children in hospital.

In a precursor to the modernisation programme of recent years in the NHS, a geriatric hospital had introduced a concept of progressive patient care to its long-stay beds, dramatically reducing the length of stay of patients, two thirds of whom could be ‘got back on their feet’ within ten days to two weeks – or were already so ill that they died. The management issue had to do with the remainder, those who neither got well nor died. In this sense the hospital demonstrated in microcosm the dynamic range of health care from the preventative to the palliative. Our study was of stress on nursing staff, this being a time of negative reports of elder abuse - then as now. We did not want to scapegoat the nurses but to take view on the systemic stress to do with care of the elderly.

I arranged to visit the families of patients, only to be intercepted at the last moment by a medical consultant, concerned that the research interviews would become a vehicle for complaints against hospital staff. In fact I heard no such complains against staff, but a lot of concern about the system, with its emphasis on returning vulnerable old people to the community. This was mirrored by comments from some nursing staff in the hospital dismayed by the interventionist approach of the clinicians, when they thought that what people really needed was TLC, tender loving care.

In the study of a children’s ward in an orthopaedic hospital, we were deliberately applying the insights of attachment theory, as described by John Bowlby at the Tavistock Clinic and explored by James and Joyce Robertson in their influential films of children ‘s behaviour when this attachment as disrupted.

In our study, we were able to demonstrate that it was possible in a clinical hospital setting to maintain a maternal presence in relation to the child – much more than mere visiting, where the mother or other significant family member felt like a spare part in an alien machine. We were also able to challenge the indiscriminate care-giving that developed around a child. We found that all kinds of staff would call by the cot unit, where the infants were being nursed, so that one small child might have to cope with up to 50 interactions with different adults in a single day. When we introduced a ban on unnecessary contact, the word got out – the Tavistock says it’s wrong to pick up children! Instead we were able to work with the staff to develop an understanding of their roles that addressed the psychological needs of the child. Mothers and family members were integral to the life of the ward, nurses and nursery nurses acted as intermediaries, when other professionals had legitimate business with the child. The integration of different systems was always subject to demarcation disputes, of course. To take a simple example: brushing a child’s hair, previous done by a nurse, would now be done by the mother, but taking the child’s temperature, a task that every mother has to be able to do at home, remained a nursing duty in the hospital setting.

This micro-study of the interactions around these most vulnerable infants demonstrated that it was possible to test the boundaries of health and social care by attending to appropriate dependency needs , but that this was not without its difficulties and would encounter both professional and managerial resistance.

The integration of health and social care systems, at both the micro and macro level has always been an issue – but what I have realised, reflecting on those earlier studies and their relevance to current issues in the NHS , is that we need first to understand why they are separated in the first place. And because the split is so deeply entrenched in the organisational culture of our welfare services, I am looking for a psychological underpinning for the rational arguments about efficiency and effectiveness and the political jargon about collaboration and partnership.

My working hypothesis is linked to Kleinian theory about the paranoid-schizoid and depressive positions in understanding the dynamics of our internal worlds in interpreting external reality. I suggest that services around vulnerable people are influenced by two states of mind, which are in a tension in relation to each other and difficult to synthesize.

My hypothesis has a societal context, and we may observe two kinds of responses of the individual-in-society to our vulnerability to accident, illness, trauma, debility. A split is enacted between the hopeful and the hopeless; the active and the passive; between fight/flight and dependence; between resistance and acceptance; between an assumed omnipotence and a supposed impotence ….

The first position may be characterised as paranoid-schizoid. The citizen is aggressive, angry about what has gone wrong in one's life. This is something that has been done to me. The appropriate stance is one of not accepting: the ills that one is suffering are not acceptable. The response is one of fighting back. After all, if you want something enough, you can have it. Failure, if it happens at all, is – or has to be - heroic. Vulnerability is for wimps.

The depressive position, which is also very much our experience in relation to health and social care, accepts more readily that there is good and bad in the world. We have to learn to live with that. Hannah Segal, in her analysis of an elderly man, 73 years old, has described how he had come to see old age and death as a persecution and a punishment. In her work with him, he came to think of his approaching death ' as a repetition of weaning, but now, not so much as a retaliation and persecution, but as a reason for sorrow and mourning about the loss of something that he deeply appreciated and could not now enjoy: life …. But the mourning and sadness were not a clinical depression and seemed not to interfere with his enjoyment of life … He might as well enjoy it and do his best with it while he could.’ She reports that he lived another fulfilling eleven years. (Segal, 1981)

How do health and social care services work with these two positions, as I have described – what we might call the heroic and the stoical? There is evidence for both, and I want to look at some examples.

In 1974, at about the same time as the action research studies that I have been describing, a reorganisation of healthcare and social care divided the responsibility for the delivery of services between separate government departments. Nick Goodwin, senior fellow at the King’s Fund, has recently commented:

‘The effect of dividing care services in this way, in the last 30 years, has led to the development of different lines of political accountability, different and competing policy objectives, and different cultural and financial regimens. Budget separation for health and social services acts as a key barrier to integration as an economic incentive was created to shift costs from one organisation to another rather then act in partnership.’

Attempts to correct some of the corrosive elements of this splitting in the concept and then in the administration of care have struggled and largely failed. In 1999 the Royal Commission on Long Term Care recommended that the costs of care should be split between living and housing costs, which would be means tested, and personal care, which would be available according to need, and paid for from general taxation. As the report stated, this would ensure that the care needs of those who, for example, suffer from Alzheimer’s Disease – which might be therapeutic or personal care – were recognised and met just as much as those who suffer from cancer.(The Sutherland Report, Executive Summary and Summary of Recommendations, London 1999.)

However this inclusive category of personal care was crucially undermined in a minority report, where two members argued against the other ten members of the commission was that while the state should make some contribution to nursing care, narrowly defined, personal care should continue to remain a means tested benefit, outside of NHS provision, As they said, they did not want to weaken the incentive for people to provide for themselves privately. The government jumped at this minority view, and Tony Blair announced (House of Commons Feb 2001), ‘We have chosen not to introduce free personal care because it would cost about £1 billion and we believe that the money would be better spent elsewhere.’

The costs of this continuing separation of the two positions on health and social care continue to undermine the overall effectiveness of the services that are being provided.

I have seen the difficulty enacted on the ground, for example in a social services day centre trying to do the right thing by the modernisation agenda. As the Royal Commission specifically mentioned Alzheimer’s Disease as an example of an illness unfairly discriminated against in the separation of health and social care, let me continue with that example. Last year, I was looking at the care for older people with cognitive impairment. There was a change from a day care focus on activities alleviating social isolation to targeted programmes addressing issues of dependency. The primary task of the day centre was described both by staff and management, who insistently emphasised that they were activity-focused, with programmes designed to meet identified needs, and not a social centre.

Need was defined in terms of a rehabilitative ethos, maintaining independent living, etc. This was then contrasted with the continuing dependency demonstrated by physically and mentally vulnerable and socially isolated service users. The task was often defined as what it was not - eg, we are not a day centre ...our approach is not about what people want, but what they need, etc. But this approach did not address the dependency needs of service users, when needs (in particular psychological needs) were redefined as wants, which were then discounted as of lesser importance.

I observed how the cognitive impairment group were kept locked away at all times, out of sight of the main centre. It was explained to me that they could not use the same dining room, or the same toilets. They had a separate entrance, so that other clients never had to come across them during the day. It was explained to me that they were not to be disturbed, or they would lose their focus. There seemed to be an exaggerated fear of their running way, or exposing themselves to other clients – or other fantasies of the severely demented.

In making a determined attempt to get away from a traditional day centre culture – which was thought to be passive and dependent, though the building had been full of lively interaction, according to legend - the service is attempting to apply a hi-tec ethos to a lo-tec activity. So all tasks were written down, routinised, Bingo (a social activity and very popular) being replaced by Snakes and Ladders (which was thought to be more developmental), allowing for very limited autonomy of staff in making and sustaining relationships with service users. Many staff were not themselves convinced by the primary task, as described above and found it infantilising of service users and themselves.

I sat at lunch with the group – one women repeated again and again, ‘Very quiet here, isn’t it!’ She told me that at home there were three generations of her family at meals. I later saw an old man, himself uncertain on his legs, get out of his car to open the door gallantly for his wife, this same woman, as he took her home. I was left to reflect on the exaggerated sense of the need to segregate these users, which would seem to promote an attitude toward dementia inappropriate for those living in the community and the declared ethos of the unit of maintaining independence.

I was reminded of the arguments that Eric Miller and colleagues were making forty years before about warehousing and horticultural models of care. While Miller was arguing against the social death that was the purpose and product of institutional or warehousing care of severely disabled people, he was not advocating a horticultural model pure and simple, encouraging independent living, if this did not take account of the reality that people need looking after and that there are social and psychological and economic costs associated with that need.

I reflected also on the work of Isabel Menzies, in examining defences against anxiety in the nursing profession. Menzies' paper on defences against anxiety is much cited, and the phenomena she described in the nursing services in a London teaching hospital are with us still as strongly as ever in nursing and other professions (Menzies Lyth, 1959, 1984). In fact the phenomenon of authority being pushed up and down the system, which she described in the hospital, is now to be observed writ large in the NHS. I am thinking of the relations of the Department of Health and the Secretary of State with the Chief Executives of the NHS Trusts, and then throughout the hierarchies and inter-professional relations of the NHS workforce.

More recently Andrew Cooper, Professor of Social Work at the Tavistock & Portman NHS Trust, has argued that there is an important paradigm shift in the delivery of services. The shift is from an attention to 'human emotional needs, human histories and the social relations that produce personal and social adversity' to a concern with barriers to opportunity. He quotes a recent Cabinet Office paper: 'The majority of families in this country are doing well. Incomes are rising, education standards are higher, there are greater opportunities and improved wellbeing. But a minority of families – around 2% of the population – have simply not been able to take advantage of these opportunities.' (Reaching out: Think Family, Cabinet Office, 2007:1)

Opportunity here is linked to capacity, and is evidenced by performance, ultimately by performance in the labour market. This includes a disabled social care service user finding that funds are directly payable to them to purchase care in the local market of supply and opportunity. At the same time the extension of governance has served to disperse responsibility for the provision of welfare across sectors, the olds public sector, the private sector, and the independent or voluntary (not for profit sector.)

Cooper’s argument derives from a study that he and Julian Lousada, also of the Tavistock Clinic, carried out on what they have called Borderline Welfare: They make a distinction between deep and shallow welfare: ‘The fear is that once we allow real contact with a deprived, dependent, helpless population, any services offered to them will become rapidly enslaved to their needs for all time, draining resources from other important projects, and depleting our autonomy and flexibility as a society and an economy.’ They go on: ‘It is not dependency that is the problem, but fear and hatred of dependency, which destroys the link to the source of support that may be the ground of our well-being.’(Borderline Welfare, pp 194-5)

The implications of my argument are, I think, significant. The policy making agenda is predominantly heroic, being driven by political urgencies. The stoical agenda is carried more by Janus-headed managers, looking both ways at economically-driven targets and at the psychic pain of their client communities, the front-line workers, informal carers, and most importantly those who are at any time in our society its vulnerable population – and potentially of course that could be any of us.

So I would argue for more respect to be shown to appropriate dependency in our society, and a continued investment in action research studies of services, including those that focus on the needs of those who in the short term are not going to die or get better, in ways that these can inform policy on the integration of services. Get that right and the opportunity agenda will have more chance of succeeding.

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