

The integration of health and social care – is it a psychological possibility?

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Tim Dartington

Abstract

I review previous Tavistock Institute studies of systems of care, make reference to more recent work, in order to engage with the question – what is endemically problematic about the integration of health and social care.

I describe aspects of more recent consultancy experience in support of my proposition that the integrative programmes associated with the modernisation agenda for the NHS are experiencing the same underlying difficulties. This is because they are doing little to address the dynamics of splitting and projection in working relations within and between health and social care agencies.

I outline further my hypothesis that we see a continuing struggle to make and maintain distinctions between health and social care, for example in their financing, despite the continuing and persistent apparent wish to integrate these services. We continue to suffer from the issues of splitting between services which are interventionist, short-term, results focused, and services which take a more 'depressive position' approach to morbidity and physical and mental dependency.

I explore the issues raised in relation to policy and practice around dementia, which I describe in the context of societal anxieties about death and dying.

In conclusion, I return to the question whether health and social care can ever be integrated.

Introduction

Integrating health and social care presents a great challenge, in developing services in a counter-dependent societal culture. Certain questions persist, despite all attempts at modernisation and partnership arrangements:

Why the fragmentation of services?

What would encourage integration?

What is depressing about social care?

What could alleviate the depression?

At its most raw and also at its most political, the split between health and social care is about celebratory omnipotence and a distancing from vulnerability. The split is so deep-seated within our culture of public services that it cannot be explained only in terms of rational debate. Moreover there is the lack of success in attempts to remove or ameliorate the distinction, where it is generally accepted to be dysfunctional and harmful to those for whom the services are developed. This suggests that the distinction meets a deep if unacknowledged need in all of us in responding to cracks in the human condition.

My working hypothesis is that a split is enacted between the hopeful and the hopeless; the active and the passive; between fight/flight and dependence; between resistance and acceptance; omnipotence and impotence

My hypothesis has a societal context. There are two kinds of responses of the individual-in-society to our vulnerability to accident, illness, trauma, debility.

The first 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 adolescentiation of society would have to be the subject of another paper, but I will attempt a brief summary here:

The characteristics of adolescence have to do with transition and transformation. The only makeover that used to matter was puberty, when the body changed from that of a child to that of a woman or

man. The process does not take long, a few months at most. But the process of adolescence has now stretched to extend from mid-latency, as children dress and act like their fantasies of adults, into adulthood and is continuing to expand into middle age and all aspects of life.

Adolescence is a state of mind characterised by desperate but temporary attachments, fierce competitiveness and a preoccupation with status. It is crucially self-absorbed, confusing high ideals and selfish acts. Its morality is built on ideas of fairness and the ambition to get more and more in order to get one's fair share. What was a temporary phenomenon while the hormones kicked in has become a continuing narcissistic love affair.

It is in this context of opportunism and unhappiness, of individualism and insecurity, expressed for example in the simultaneous expansion of obesity and health clubs, sex outside rather than in relationships, the lack of dependability of institutions of all kinds, linked to continuing conspicuous consumption and high levels of personal debt, that we may see how any vulnerability is experienced and expressed as a threat to identity.

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, interviewed on the radio this summer about her childhood and the death of her much loved older sister, said, yes, I experienced trauma, as we all do. 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)

On the anniversary of the London bombings, a journalist protested at the media coverage of the trauma experienced by some victims – not that the trauma was not real – but that no interest was shown in the capacity of the majority to pick themselves up and go back to work the next day or the next week.

In his book, *The Consolations of Philosophy*, Alain de Botton describes the experience of Seneca, who had the good fortune to be the tutor to the emperor, and the bad fortune that the emperor was Nero. The Emperor had already murdered his own intimate family and was feeding his senators to crocodiles and lions. Fearful of conspiracy wherever he looked, he sent a soldier with the command that Seneca take his own life. The philosopher's companions were in despair, but Seneca,

was, at you should expect, Stoical. 'Surely nobody was unaware that Nero was cruel' he said. 'After murdering his mother and brother, it only remained for him to kill his teacher and tutor.' (de Botton, 2000, p76.)

How do health and social care services work with these two positions, as I have described – the heroic and the stoical? As I have said, I am linking the first with more with the paranoid schizoid in terms of Kleinian psychoanalytic theory and the second more the depressive position. (Klein, 1946) There is evidence for both, and I want to look at some examples.

Reviewing Tavistock work on vulnerability

I went to the Tavistock Institute in the 1970s to work with Isabel Menzies Lyth, and Eric Miller on institutional and hospital care and the needs of vulnerable and dependent people in society (Menzies Lyth, 1959, 1988; Miller 1993).

Miller and Gwynne, describing work with severely disabled people wanting to escape the unnecessary dependencies of institutional life, described a kind of social death which those institutions provided for. 'Their intake consists of people who have been extruded from the wider society and for whom, by and large, there is no going back. In other words, the institutions import the socially dead and export the physically dead.' They described warehousing and horticultural models of care, neither of which, they emphasised, was satisfactory on its own. (Miller & Gwynne, 1972, p. 161)

Much has changed in the NHS over thirty years, but many of the issues remain disturbingly familiar. There continues to be a powerful underlying dynamic in health and social welfare systems providing services to old people. This is the pervasive and persistent dynamic of fragmentation between health and social services. Rachael Davenhill has drawn attention to what she calls 'the false distinction embedded in current government policy agreeing to pay fees for nursing care and not for 'personal care.'" Her concern is that 'this serves to dehumanise the real meaning of nursing and the truth of its function in containing the holistic health needs of the older person both physically and emotionally.' (Davenhill, 2004) Why is there this fragmentation? Is it that the task is in a societal sense, too difficult? Too much associated with failure? We talk of someone with failing health. Of heart failure – and of a failure of services to provide what Anton Obholzer has called a Keep Death at Bay service (Obholzer 1994).

(a) Isabel Menzies on nursing

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. Menzies would say, no therapy without research - no research without therapy, The essential characteristics of this approach is that it is collaborative. It means working alongside people in identifying issues that they find difficult and painful. And it has the potential to support and encourage the necessary autonomy of the effective worker and to counter the effects of an unexamined culture of dependency.

There is a question we can all ask, wherever we fit in an organisation where we are working: why do we do things the way that we do them? It is a question that we should keep asking ourselves. The answer we come up with is multi-faceted. How we manage ourselves in work is of course constrained by our understanding of how we may work most effectively in carrying out complex and difficult tasks. How we do things has to do with the all kinds of technical and practical issues and also policy issues.

But there is also another important set of considerations that usually go unexamined and unobserved. We manage ourselves in order to defend ourselves against anxiety, the underlying fear of annihilation, what Bion called 'nameless dread', which from birth is part of the human condition (Bion 1962). Otherwise we would not be able to function effectively and creatively. Menzies described in more detail the anxiety that nurses may experience, through their intimate contact with the vulnerability, both physical and mental, of others. We are uneasily open to this anxiety every time we are in a new and strange situation. This is as true at work as in any other aspects of our lives. This is why it is important that we are clear about our roles and responsibilities, and that we have clear procedures, training, supervision, supportive management. However even if we have all of this in place, it may not be enough.

Menzies showed that responsibility for intimate care of sick and dying patients resonated painfully with the nurse's unconscious anxieties; this made the nurse's individual defences precarious; and various mechanisms in the social systems of the hospital could be seen as providing supplementary shared defences against these anxieties.

I would emphasise that defences against anxiety are not bad in themselves. As I have said, social defences are necessary to the everyday fraught business of living. The question is, are the defensive behaviours that we observe in ourselves and others functional or at times dysfunctional not only in

carrying out the work - the overt task - but in doing the essential undercover work of helping us to feel that we can achieve psychic survival in the business of living.

Menzies describes how social defences in nursing – like the misdirection of responsibility up and down the system - may be dysfunctional, as ‘nurses are deprived of positive satisfactions potentially existent in the profession, for example the satisfaction and reassurance that comes from confidence in nursing skill. Satisfaction is also reduced by the attempt to evade anxiety by splitting up the nurse-patient relationship and converting patients who need nursing into tasks that must be performed ... Success and satisfaction are dissipated in much the same way as the anxiety ... The poignancy of the situation is increased by the expressed aims of nursing at this time – to nurse the whole patient as a person. The nurse is instructed to do that, it is usually what she wants to do, but the functioning of the nursing service makes it impossible.’ (Menzies, 1959:1988, p.70)

In a major action research study of children in hospital, Menzies also went further in analysing ways of overcoming the multiple indiscriminate care-taking of institutions, ‘where the child has no figure he can in any way call his own but has a succession of transitory care-takers who look after all the children indiscriminately’ (Menzies,1982: 1988, p.157) – still I would say the template for many services for vulnerable people of any age. Her emphasis on the importance of the maternal role in contemporary society– a containing role that is crucial to the management of loss - is linked with the society’s defensive relationship with death and mourning, and a tendency to institutionalise problems felt as too difficult to confront. (Menzies, 1975:1988)

(b) Care of the elderly

The ambivalence in society about hospital care of the elderly is captured for me by the following experience. A Tavistock Institute action research study at Cowley Road Hospital in Oxford followed a series of harrowing reports and inquiries on care of the elderly: the Department of Health was worrying about the stress on nurses, and in Oxford there was a pioneering and charismatic geriatric physician was implementing radical proposals for what he called progressive patient care, so this seemed a good site in which to explore an open systems approach to the nursing experience of working with the elderly (Miller,1993). But the old people and their families who we interviewed identified the hospital as the old workhouse and the last place they wanted to end up – and not even then if they could help it, with its workhouse associations of separation and social disgrace. Some years and several NHS reorganisations later I drove down the Cowley Road, and there were placards everywhere - Save Our Hospital – as the local people protested about the impending closure of the hospital and the loss of an important resource to the community.

The action research study at Cowley Road Hospital was led by Eric Miller, a social anthropologist and a colleague of Menzies at the Tavistock Institute. Miller had already done a study to do with physical disability and had explored the concept of social death, after he had seen that institutions were made up of people extruded from the wider society and for whom, by and large, there was no going back (Miller & Gwynne, 1972). This was not a counsel of despair. But it did require an integration rather than a polarisation of what he called warehousing and horticultural models of care. Neither on its own was sufficient.

Hospitals of course only exist because we are not immortal. There are two inscriptions that you might look to see as you enter a hospital. The first is from Dante's *Inferno*: 'Abandon all hope, ye who enter here.' Some people try their hardest to avoid going there, despite the encouragement and good arguments of professionals, family and friends. Even for a visitor, it can be a scary place, and we look anxiously at our watch as we want to get out. And there is reality. Very many of us will die in hospital. But you may also look for a second inscription over the door, from the poem that Dylan Thomas wrote for his father: 'Old age should burn and rave at close of day; Rage, rage against the dying of the light.'

In the Cowley Road Hospital study, some patients got better quite quickly, and some died quite quickly. They offered no problem to the system. But those who neither got better nor died were an institutional headache. When the geriatrician arrived, they had occupied over 80% of the beds. He had been able to reduce that number to 2%, where a continuing care patient occupied a bed for more than twelve months.

We observed a process of integration and fragmentation, where a discrepancy emerged between what was the overt task of the staff working in the hospital system and what appears to happen to the patients at different stages of the treatment and care (Dartington, 1979). This discrepancy, which emerged on the first day of the patient's stay in the hospital, results from a splitting of perceptions of what the hospital is supposed to be good at, providing specialised medical and nursing and other care, and what the community is perceived to be bad at, maintaining old people as functioning and valued members of society.

Ms S., aged 80, lived with her daughter and son-in-law. She had a fall and the GP arranged her admission to the general hospital. She was to be discharged home after one week, but her daughter was in ill health and the son-in-law protested against the imminent discharge. Mrs S was transferred to an acute geriatric ward at Cowley Road Hospital. She made slow but enthusiastic progress towards mobilisation and rehabilitation and her family visited regularly. But when the attempt was made to discharge her home, the family could not cope, and in this they were supported by their GP. The son-in-law wrote to the hospital: 'To have her back here is crazy ... put her in any home you wish, but certainly not in mine.' Mrs S. was transferred to the long stay ward.

The tensions between the hospital and the community were replicated within the hospital between the acute and the long stay wards, and in the tension between a medical leadership to do with intervention and a nursing response to do with giving comfort to those in distress.

(c) Innovation from within

A Tavistock Institute colleague David Towell was a social science adviser at the same time at Fulbourn Hospital near Cambridge, where he worked with the staff in designing and implementing innovative programmes to meet perceived deficiencies in the care being provided to patients (Towell & Harries, 1979) Here is one example, from a psychogeriatric ward.

The staff were encouraged to ask the question – how to improve patient care on the ward? They then asked, how did the patients respond to reality? Some were aware of what was going on around them, they were the easiest patients to get on with. Others needed more support and encouragement. Finally, there were those who seemed to be most out of touch with reality. These were the most difficult to look after, and they thought, the most neglected.

Then the staff looked at themselves. Their time was important if they were going to do anything new with patients. They felt that most of their work was making sure the patient was dry, and in the task of dressing, toileting, feeding and so on, with little time for less obvious needs, specially when they were short staffed. So they looked at what they were actually doing. They drew up a list of activities they were doing and then a simple time system, where they recorded which activity they were mostly doing in each 15 minute period and they did this for ten consecutive shifts. They researched themselves in fact.

Their own predictions were more or less accurate. Nearly half their time was taken with meeting the physical needs of patients, and one-fifth towards their mental needs, for example in talking with patients. But they also noticed that they had a rigid routine. At certain times of day every one was doing the same thing, all getting people dressed, or feeding, or bedmaking. When there were more staff, they all did the same activities as well, the physical routine tasks and there was little difference to the time available to be with patients.

From their analysis of the dependency needs of the patients - a careful process that took ten weeks –they realised that they spent most time with the high dependency group, because they had the most physical needs and with the least dependent group, who were easiest to relate to – the group

who were neglected were the intermediate group, who were neither ill enough nor showing signs of improvement to merit their attention.

They became more flexible in their approach. The day staff talked with the night staff and they agreed that the night staff did not have to get all the patients up before the end of their shift. And the patients did not all have to have breakfast at the same time – some had been sitting waiting for an hour or more under the old system. While it had been quicker for the staff to do everything for the patients, now patients were able to clear away their own tables. And so throughout the day, which no longer stopped at 4 pm with a last meal of high tea. There were negotiations with the domestic superintendent to have an evening domestic to wash up later. The staff found that patients were less incontinent and more responsive to their environment. All agreed that the work was more satisfying and interesting, and that they knew more about the patients and what was going on in the ward.

What made it possible for them to do this work? Miller described the necessary conditions as follows: 'By my definition every employee is a manager ... The notion that groups of staff have the capability and authority to take initiatives and that it is the task of managers of wider systems to provide the boundary conditions within which nurses and other staff can perform their task more effectively seems, however, to be at odds with the culture of prescriptive superior-subordinate relationships that prevails in the NHS generally.' (Miller, 1979, p.190)

Since then, the NHS has changed and changed. It seems an age since we were saying to clinicians that they were managers – before the introduction of general managers and then of ever more insistent external systems of audit and control. We saw how the focus of the dependency relations changed with the shifting balance from institutional to community care. But the nature of the dependency has changed very little, as it serves a function of keeping at bay the feelings of anger and aggression that the work arouses (Dartington et al, 1981).

One nurse at Fulbourn Hospital reported that she was thinking about the ward when she was at home and trying to think of other things to make it better. A couple of nurses recognised that they found it difficult themselves to make the adjustment from the old rigid routine. And Towell and Miller knew that it would not take much for the experiment to lose impetus. Nevertheless, this is an example of what can be done if there is recognition of a proper autonomy at the local level. And it also says a lot for a methodology based on careful observation, in conditions of sufficient trust and containment that allow for some integration of a warehousing approach to intractable problems and an aggressively interventionist approach.

The integration of care - the example of dementia

Dementia is an issue that is causing increased anxiety in the planning and management of health and social care systems. Cognitive impairment is estimated to affect three quarters of a million people in the UK at this time. It takes different forms, including vascular dementia, Lewys Body disease, and many other different conditions, but the most common is Alzheimer's Disease: a diagnosis of probable Alzheimers is given in 55% of cases – usually diagnosis can only be confirmed post mortem.

Dementia is related to age – aged 60, the incidence is one in a thousand: by age 85, this has risen to one in five. The social anxiety about this condition is therefore linked to demographic changes – more people surviving into old age means more people developing Alzheimers. This is confusing, because the symptoms of cognitive impairment may be mistakenly attributed to the normal processes of ageing. We learn much more readily in childhood and early adulthood – we experience increasing difficulty in later life – so called senior moments - for example in recalling names. But the cognitive impairment associated with dementia is of a different order.

We experience the threat of dementia as a loss of identity. 'He is not the person I married.' Well, none of us are, of course, but with dementia the statement takes on a different meaning. It is the apparent loss of identity that at the level of social functioning is a significant factor distinguishing this illness from others and makes it particularly frightening and challenging to existing social systems, familial systems but also health and social care systems.

In this sense it is in a tradition of illnesses that have a very powerful social meaning. Susan Sontag wrote about illness as metaphor, and about two illnesses, tuberculosis and cancer.

'The fantasies inspired by TB in the last century (she meant the 19th Century) by cancer now (she was writing in the 1970s) are responses to a disease thought to be intractable and capricious – that is, a disease not understood – in an era in which medicine's central premise is that all diseases can be cured. Such a disease is, by definition, mysterious. For as long as its cause was not understood and the ministrations of doctors remained so ineffective, TB was thought to be an insidious, implacable theft of a life. Now it is cancer's turn to be the disease that doesn't knock before it enters, cancer fills the role of an illness experienced as a ruthless, secret invasion – a role it will keep until, one day, its aetiology becomes as clear and its treatment as effective as those of TB have become.' (Sontag, p.5)

What is remarkable to me about this passage is that forty years on, exactly the same could be said about dementia: intractable and capricious, mysterious, the insidious implacable theft of a life – a ruthless secret invasion. Clearly dementia has taken its place in turn as the disease that is a metaphor for a life destroyed by a malevolent twist of fate.

As a society we do not believe in acts of god, the let-out clause in insurance policies. Every attempt is being made to tie down any and every tragic event to human agency. Whatever goes wrong, someone is at fault. This of course is the basis for a litigious society. If a mother kills a child, a social worker is at fault – it is only a sophistication of the argument to say that there was a systemic failure. If there is not a straight line of argument to identify the perpetrator, a scapegoat will do. In our day the oracle would need to take out professional indemnity and Oedipus could have sued the Sphinx for miss-selling.

We still use oracles. Michael Wood has written about oracles ancient and modern. 'The doctor represents, to the best of his or her authority, the advice of the god – the god in this instance being a name for the best medical information of the time. The patient hears then advice, indeed has presented herself or himself at the place where this advice is formally dispensed, and must now decide whether to act on it or not. The patient in a modern hospital doesn't much resemble an ancient Greek city-state; but the structure of question and response, of mingled authority and freedom, is remarkably consistent over time.' (Wood, 2003, p 219)

A disease without a known cause is provocative to our modern sensibilities in a way that has important repercussions in the way that we respond. The default position about any tragedy is that if another cannot be held to account, then the fault is one's own. A painful example was given by Helen Bamber in her paper to an OPUS Conference in 2004 – when she described the plight of child survivors of the concentration camps, brought to this country as a humanitarian gesture, and then made to feel that the enormity of what had happened to them had somehow to be their fault.

Diseases with an intractable aetiology are not well addressed by services that are interventionist. An intervention as such is likely to be understood as having little or no useful outcome. We may illustrate this by looking at the argument about dementia drugs. There has been considerable controversy, because the National Institute for Clinical Excellence (also known as NICE) (George Orwell could not have made this up) has made a judgement that some anti-dementia drugs, donepezil and others, would not be available on the NHS until patients had reached a 'moderate' stage in the condition. The drugs improve memory and can make daily tasks easier, but patients have to deteriorate into a state, where they show confusion and fear before getting treatment.

The economic models used to justify the withdrawal of these drugs are based on QALYs (Quality Adjusted Life Years), which attempt to measure how quality of life relates to the severity of illness. (The basic idea of a QALY is straightforward. It takes one year of perfect health-life expectancy to be worth 1, but regards one year of less than perfect life expectancy as less than 1, in the case of dementia a lot less.

Of course in the example of drugs that relieve suffering but do not stop the progression of a degenerative disease, the formula may not show a clear cut benefit. An antidementia drug that costs £1000 per year is given a QALY adjusted cost of £80,000, - put another way, you would have to treated up to 80 patients to achieve the culminative effect of just one quality adjusted life year. (At least I think that's what it means. The process may be transparent but it is not easily comprehensible even, as I have discovered, to senior and experienced clinical consultants.) Anyway, this is way in excess of a supposed QALY break even cost benefit level of £25,000.

It is no use pretending that QALYs are anything but a crude measurement. But the use of QALYs in resource allocation decisions does mean that choices between patient groups competing for medical care are made explicit. QALYs have been criticised because there is an implication that some patients will be refused or not offered treatment for the sake of other patients and, yet such choices have been made and are being made all the time. Polly Toynbee has made a spirited defence of the system. 'Founded in 1999, it [NICE] is one of the best things Labour has done for the NHS. Here is an entirely open and transparent system to manage the rationing that is an inevitable part of every health system, publicly funded or privately insured.' (The Guardian, 24.10.06, p33.)

So NICE concluded that while the anti-dementia drugs were clinically effective in both the early and moderate stages of the disease, supporting the findings of more than 30 clinical trials, with benefits to key self-care skills, as well as memory and thinking, and additional benefits in important areas such as confidence and mood, nevertheless they were not value for money. The reduction in the costs of carer time was seen as irrelevant to their analysis, and I can see why. The social costs are to be kept quite separate from the health costs, which were their concern. That would require the joined up thinking that is often espoused but, I have argued, rarely seen in practice.

Guilt and Punishment

The ultra-rational use of QALY thinking is also, I now suggest, a front for other less rational processes, where the victim is assumed to be complicit in the perpetration of the offence. If something is perceived to be your fault, however unconsciously expressed, then one thing is sure – that you will be punished. I observed this when I was looking at attitudes to disability in a Tavistock Institute action research study in the 1970s – the same time as the Sontag paper.

I remember interviewing someone who could not speak. We used a crude letterboard. He explained how he was afraid of the people who worked with him because he was in their power. A care assistant brushing his hair would hurt him and he could not protest – and if he did, no-one would take him seriously. Imagine that prison. He was being punished because he was disabled, because of the trouble he was causing by existing.

I became aware of ways that we are fearful of those who are weaker than ourselves, because of the demands that they put on us. I wrote then about how a professional audience responded at a conference to a presentation by a disabled resident in a new scheme. She explained how the staff on the new unit were working to fulfil her needs and to carry out her wishes as far as possible to give her some freedom of action – the same as that of an able bodied person.

The reaction of the professional audience was, to judge by their comments, to be frightened. They decided for themselves that staff would not tolerate such autocratic behaviour from a resident, though the speaker had contrary evidence from her own experience. It was the considered view of the audience in their group thinking that the residents would make the lives of staff intolerable or they would kill themselves. 'Left to themselves, the disabled would destroy us or themselves.' (A Life Together, p. 69.) I described this as a position of enlightened guardianship.

More recently last year, I was looking at the care for older people with cognitive impairment in a social service day centre setting. 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 repeated and insistently described both by staff and management – emphasising that they are activity-focussed, with programmes designed to meet identified needs.

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 is not - eg, we are not a day centre ... it is not what people want, but what they need, etc. This approach, while it is consistent with government policies relating to care in the community, does not address the dependency needs of service users, when needs (in particular psychological needs) are redefined as wants, which are then discounted as of lesser importance.

They knew about the Cognitive Impairment (C.I.) group that also met at the centre. Some of them also worked with this group. Not all, not for example the driver/carer who related to the clients all the time through banter, needing a response, and these clients were no good for him, because they did not respond. But some others got a certain satisfaction out of working with this group.

I observed how they 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. They found it infantilising of service users and themselves.

I sat at lunch with the group – one woman repeated again and again, 'Very quiet here, isn't it!' At home she said 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. The respect shown to the service users was evident, but the protocols were very limiting, with 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 ethos of the unit of maintaining independence.

Paul Terry has described how projective identification justifies the inadvertent neglect of older people – where fears of dependency, loneliness and death are disowned and projected into the older person. He describes an observation of people with dementia and their interactions with carers and family visitors. 'They are painfully losing their independence and losing their mind. However the carers and the visiting wife contribute to these losses by infantilising these old people. Treating them as children is projecting dependency into them and effectively stealing any remaining independent capacities for thought or action that these people may have left.' (Terry, 2006)

Those working in a service for people with dementia , are made to feel helpless by the disease. As Jane Garner, an old age psychiatrist, has described, they experience 'a major assault on our therapeutic narcissism.' More specifically, she says:

'Working with someone with an irreversible illness may stimulate hostility, helplessness, frustration and therapeutic nihilism Unconscious determinants of our chosen healthcare profession may not be satisfied by patients whose condition is chronic, even deteriorating ... The patient who does not get better may provoke feelings of aggression and sadism accompanied by anxiety, guilt, depression and reparative wishes.' (Garner, 2004, pp 221, 223.)

Andrew Cooper and Julian Lousada make a distinction between shallow and deep 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.' (Cooper and Lousada, 2005, p. 194.).

They describe a state of mind associated with globalisation, where there is a necessity of permanent adaptability, and strong attachments are to be discouraged – as also Richard Sennet had described in his book, *The Corrosion of Character*. (Sennet, 1998) The supposed interdependence of a globalised economy in fact exposes our dependence, which is both hated and feared. I think the OPUS global listening posts also support this thesis. (Stapley and Cave, 2006.)

Integration and alienation

What we have seen in the development and delivery of services is an increasing division of labour at the same time as there is an awareness of the need for integration of services around the needs of the whole person. Why this division of labour?

In a study for the King's Fund I looked at the way services manage the conflict of interests around the care of elderly mentally infirm people. 'Each of the interested parties has its own perception of what it is good at – and what it ought to be doing – and often does not see caring for the frail elderly as its primary purpose. If social workers think their skills are best used on case-work with families with children; if a nurse gets job satisfaction from comforting the sick; if medical resources are concentrated where they can produce the most dramatic results; or the family is seen as a social and economic unit devoted to bringing up of children; then social workers, nurses, doctors and families have to find other reasons for wanting to choose to look after elderly mentally frail people.' (Dartington, 1986, p.27.) I argued then that the best hope was through collaboration, as no one service on its own was going to prioritise meeting this need.

We understand the rationale of division of labour in manufacturing – first of all in pin making factories, as observed by Adam Smith, later in motor cars, as exploited by Henry Ford – but in human services the rationale has to be different. We have a continuing development of specialisms – and, so it seems, the need to create the equivalent of the assembly line as the individual patient or client is assessed and reassessed according to all kinds of different criteria, for a multiplicity of needs. But this image of the assembly line is not correct – our experience is more non-linear than that. For a social services client, negotiations might need to take place with up to twenty other organisational units, GPs, health visitors, CPNs, home helps, hospital services, old age psychiatrists, residential home managers, physiotherapists, occupational therapists, day care centres There is not one

overall organisation to act as container to appreciate and reward collaboration (Dartington,1986). Attempts to deal with the fragmentation in piece-meal fashion have led to a loose amalgamation of professions and functions, in community mental health teams, for example, leading to people feeling deprived of identity and respect - as they see only too vividly in their clients.

More modern philosophers than Seneca have argued that assumptions based on tradition have to be tested against what we find the world is like. Maurice Merleau-Ponty, a contemporary and both friend and rival of Sartre, talks both of conscious memories in an historical sense, but also unconscious interactions with the world, so that the unsuccessful solution to old problems linger on as habits, what he calls a process of sedimentation (Matthews, 2002) , the process we now observe in grumpy old men and women. You may observe this sedimentation in dementia, where there can be a return to a sense of selfhood if the surroundings are right. For example a dementing person, while aggressive at times may keep a sense of the importance of politeness. Equally there can be a destructiveness of the sense of self, if the context is antipathetic to tradition. Margot Waddell has noted how primitive mechanisms of communication – eg, through projective identification – as relevant at the end of life as at the beginning. ‘Care of the very elderly, those so often lacking the capacity to speak, yet so intensely riven by extreme emotional states, requires a painful reversal of the original pattern of container/contained (the young now struggling to offer states of reverie to the old.’ (Waddell, 2002, p. 249)

This sense of losing role and therefore identity is key to understanding of the concerns facing those working in a multi-disciplinary context. They are unconsciously allied with the older person who has lost a definitive role in society – a role where they know they could be useful to others but a role that goes unrecognised and unvalued.

So we may see how the issues raised in a consultation with front-line workers about their clients is of the greatest importance for thinking about the overall management of services. The challenge for management is that it is not enough to integrate people – eg, in multi-disciplinary teams – if you do not also integrate the systems in which they are expected to work.

There are, I suggest, two alternating perceptions of management at work, alternating in the sense that it is possible to flip from one to the other in a moment and without notice.

The first perception is of management as out of touch, arbitrary and deeply problematic – perhaps like a dementing parent, out of touch with what you are having to struggle with. This management has to be mollified, ignored, reluctantly loved and actively hated.

The second perception is of management as a caring parent, doing her best in impossible circumstances, understanding of our difficulties, someone we don't want to put pressure on, but sometimes we need to take out our frustration on. This management is seen as exhausted, needing but without recourse to respite care.

Closing the long-stay institutions and developing community-based services in their place does not do away with the dynamics of exclusion. Not at all. The long process of transferring depressive human services to obscure and ill-defined community locations while continuing to invest in fewer and fewer megacentres of excellence for heroic interventions has been a very important story of the counter-dependent NHS in recent years. Furthermore, the management challenge in this import-export business of health and social care has also now to provide for the unmet dependency needs of staff in the context of a can-do management environment looking for short-term outcomes. Performance targets can be painful. To meet targets on delayed discharge from hospital, it may be necessary that mortality in the elderly population reaches or exceeds the projections in last year's forecasts. Managers, distanced but not out of touch with the previous clinical identities, are very uncomfortable to find that they are thinking in this way. And yet the underlying realities of social death continue to affect the implementation of policy. The cost per week of residential care for older people is currently around £550 –600, while for an adult it is estimated nearer to £950. Such is the depreciation in your social value as you get older.

What then can we do to relieve the conflictual pressure that everyone experiences in attempting a holistic approach to the needs of vulnerable people and to allow for the expression of caring and therapeutic skills? In the integration of health and social care, there has to be respect for difference. Otherwise a part of the reality is always going to be obscured. As Vega Roberts and I discovered when we were consulting to the integration of services in a care trust, incontinence has a primary meaning to a health worker of infection, while to a social worker it immediately means a loss of independence. There is a lot of careful work to be done, giving space for thought at all levels in the organisation, in the integration of services, and in new forms of integrated organisations like care trusts.

Reorganisations, with their emphasis on generic teams and partnerships, will often seem to drive professional groups into competition with each other, by forcing them into an intimacy for which they are not yet ready, rather than the co-operation that is necessary for survival and to keep the whole person in mind in providing services. Date rape followed by an arranged marriage are not good models for organisational collaboration or for overcoming the real suspicions and mistrust of systems that were constructed on opposing and conflicting principles.

Tim Dartington

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