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Mini Therapeutic Communities – A New Development in the United Kingdom

Steve Pearce and Rex Haigh

ABSTRACT: Recent years have seen the decline of the residential TCs in the NHS, as threats to such places as the Henderson, the Cassel and Francis Dixon Lodge have led to them restructuring their programmes and assessing their future. Webb House has closed, Francis Dixon Lodge has moved to a day TC model, and the Henderson is at the time of writing (early 2008) under serious threat of closure. At the same time the number of day TCs (three to five days a week, non-residential) has expanded, and in the last couple of years 'mini TCs' (one to two days a week) have arrived. This paper charts the progress of these developments in the NHS, and draws conclusions and lessons from it relating to the current commissioning climate – and the need for TCs to learn and adapt. The example of the development of a mini TC in Oxfordshire is given as an illustration.

Introduction

Q: How do you tell the difference between the members and the staff in a TC?
A: The members are the ones that get better and leave.

Staff can become over-attached to their way of doing things and to the habits of their particular TC, coming to believe that other ways of organising a community are not as good. Set against this background, the last three or four years have seen an explosion in creativity and activity in the TC sphere in the UK, brought about in part through the National Personality Disorder Development Initiative from the Department of Health, which has provided funding for a range of new approaches to the treatment of personality disorder in the NHS, many of which have either a TC 'flavour', use various elements of the TC approach, or vary very little or not at all from the TC core service standards (see description of ways in which mini TCs might vary from core service standards,

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below). In spite of this expansion, both in the number of TCs and in the range of settings (for example without dedicated space, gardens, kitchens) they use, the view of the wider commissioning and policy bodies is generally to dismiss the longer term future of TCs (Benefield 2007). This appears to be because of the lack of evidence that is being produced in the field, along with a belief that TC practitioners are generally reluctant to engage in evidence-based practice as required of others, or to update or modify their practice in the light of evolving circumstances.

The development of new models of Therapeutic Community

Competitive pressures are all around us, and therapeutic community practitioners are often not expert at publicising the advantage of TC treatment approaches in the right place and in the right way. Some of the pressures that are around may be to do with professional territorialism: people support a model in which they have been trained, or that they believe in, and consider alternative models inferior. This may become more obvious under the current pressure to deliver 'value-for-money', 'evidence-based' therapies – particularly at a time when many Primary Care Trusts (commissioners), Health Authorities (performance managers) and Mental Health Trusts (providers) feel pressure to provide new services, for example personality disorder (PD) services, without extra funding to do so.

There can be several levels to this competition:

- between therapeutic approaches – cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), cognitive analytic therapy (CAT), mentalisation-based therapy (MBT) and so on can be seen as competing rather than complementary models;
- between NHS providers in mental health trusts, the forthcoming 'semi-privatised' foundation trusts, and independent competitors – this will be more and more so as a range of public, private and third sector organisations start seriously competing for NHS resources once 'contestable commissioning' (which means a free market for health services) really arrives;
- within existing NHS mental health services, between providers of therapeutic and radical approaches (such as therapeutic communities), and the clinicians and providers engaged in mainstream mental health services – which can become dominated by risk-averse and procedure-driven models of care.

An important development has been the move towards 'lower dose' programmes for TCs. To many, particularly in the NHS perhaps, the term 'therapeutic community' meant a residential unit, with the few day units sometimes not even being recognised as 'proper' TCs; some clinicians working outside the field are still surprised at the existence of non-residential TCs. In the last few years some residential programmes have come under threat particularly in the British NHS, both through a lack of good evidence for effectiveness and downward pressure on treatment costs, and the programmes

which have less time physically together in the community, on the premises as it were, have expanded in both numbers and scope. This development takes a number of forms.

- The 'maximum dose' non-residential programmes are five days per week, and some of these have half days. One of the longest standing is Winterbourne House in Reading, which like a number of these TCs was initially a residential admissions ward but has now been operating as a five-day-TC for over 20 years.
- There are several new TCs now operating on a three days per week programme, in order that other therapeutic activities can happen on the non-TC days, because of budgetary or staff time considerations – or simply because of a belief that it is possible to provide a suitably intense and effective treatment in three days per week. One of the earliest examples was the Brenchley Unit in Maidstone, which has now been operating for seven years.
- More recently a considerable number of 'mini TCs' have developed, which have therapeutic programmes lasting for less than two days per week. One of these will be discussed in more detail later. Diagram 1 lists mini TCs and anticipated mini TCs in the UK; all but one have been founded within the last four years.
- The above three models all involve 'traditional' TC staff roles; but there are also innovations such as the 'Edinburgh model', where an active service user group has developed a web-based forum for support – and which evolved over a matter of months into numerous regular physical meetings of various groups. Like Bion's (1960) TC at Northfield, a wide range of different groups has spontaneously evolved for those involved, originated, developed and coordinated by the participants themselves. At Northfield, it was in the nature of a battle chart, with coloured flags for the groups – in Edinburgh, it is run as a collection of internet discussion groups, hyperlinked together. The groups have also evolved their own boundaries and rules, guidelines and codes of conduct – set entirely by their own members (see example in box). This has proved successful in helping people to discuss and gain access to more formal therapy, or return to work or college; the whole system involves no trained staff input, although clinicians are available for indirect consultation if necessary – although that is very rarely used. These might be termed 'virtual TCs'.

Subgroups of BUK Edinburgh may meet independently, provided:

1) it is announced in the usual way on the BUK Edinburgh discussion board;
2) it is not exclusive of any other member;
3) the same members do not meet independently either twice in succession or more than twice weekly;
4) a volunteer or recognised established member is present.

Diagram 1: Locations of mini TCs in England

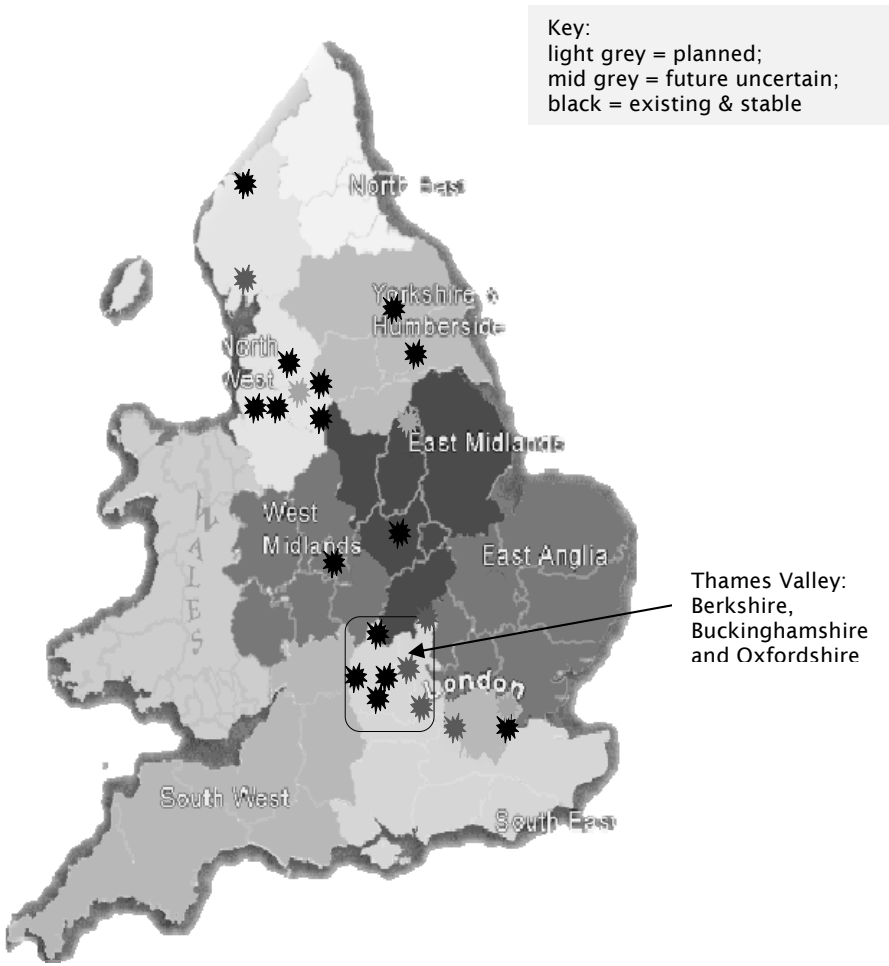

Table 1: A taxonomy of recent developments in TC methodology

Residential TCs	Overnight stays, sometimes excluding weekends
Day TCs	3–5 days a week, no overnight facilities
Mini TCs	2 days per week or less, may not involve staff in traditional ways
Virtual TCs	Usually web based

The application of the different types of non-residential TCs does not necessarily relate directly to clinical need. One member may be sufficiently disabled to require the intensity of work and containment that is provided at a day TC, while another is able to benefit from a less intensive intervention such as a mini TC; on the other hand some members may be too fragile to tolerate the intensity of input at a day TC despite being extremely functionally impaired. For some other members other commitments such as childcare or part-time employment may make a mini or virtual TC the only viable option. Our experience has indicated that a range of intensities is necessary to provide services for people with a variety of difficulties and social circumstances.

The arrival of these 'lower dose' TC models should not comprise an argument for the inexorable cutting of all TC provision until no residential or physical (as opposed to virtual) TCs exist; in terms of therapeutic engagement and the necessary intensity of programmes for people who have had very traumatic and disturbed backgrounds, a range of programmes will remain necessary. The Association of Therapeutic Communities in the UK undertook a piece of work to define the need for levels of TC provision in 1998 (Campling and Birtle 2001), and it concluded just this: residential TCs are necessary for those most in need of a highest level of containment and intensity of programme, through to lesser 'doses' of treatment programme.

This is not the way commissioners of mental health services think. The position at time of writing is that there are only three residential TCs in the British National Health Service: the old stalwarts – or war horses, maybe – such as the Henderson and the Cassel, and the Henderson's replicate, Main House. Francis Dixon Lodge in Leicester, a therapeutic community with a long history of NHS provision dating back to the days of social psychiatry, closed its beds early in 2007 to become a non-residential day unit. There are numerous other day TCs in the UK, including long-standing ones such as Winterbourne House in Reading and the Red House in Salford near Manchester, others in London such as the Cawley Centre and the Intensive Psychological Treatment Service (IPTS) at Guys in London; the resurgent Garden Villa TC at Cornhill Hospital in Aberdeen and the Brenchley unit in Maidstone. Of the newer generation there are the Thames Valley projects such as the Oxford Therapeutic Community at Manzil Way in Oxford (five days) and New Horizons TC in Aylesbury (three days), also Mandala TC in Nottingham (three days), and some locally-based spin-offs from some of these, such as the Jasmine Centre for women in Leicester and Bridger House in Birmingham.

In the last five years several initiatives around the country have independently set up mini TCs (two or fewer days per week). A number have come out of the work of Webb house for TC Services North: 'Diverse Pathways' in Leeds, '15' in Manchester, 'Rotunda' in Liverpool, '174' in Bolton, and 'Taste' in Stockport, with two more currently being planned: 'North Pennine DTC' in Bury and Oldham, and '2B' in Blackburn and Burnley. Table 2 gives a summary of developments in the field of mini TCs, and there are four service user-led TC-like projects in south-west London as part of the 'Service User Network'

programme which are essentially mini TCs – although they are rather reluctant to identify themselves as 'proper' TCs.

Table 2: Developments in the field of mini TCs in the UK

Mini Therapeutic Communities	Parent organisation	Starting date	Number of members (normal - max)	Days (hours) per week	Length of programme	Premises	Notes
Intensive Psychological Treatment Service (IPTS), Southwark & Lewisham: transition and recovery service	Guys Hospital MHT	2000	10–16	1d	12m	Acute hospital	As stand-alone or follow-up to day TC
Witney Group	Thames Valley Initiative (TVi) & MHT	2006	9–14	4½ h	18m	Com-munity Centre	
Banbury Group		2006	12–14	4¼ h	18m	CMHT	
Wallingford Group		2004	12–14	1½ d	18m	Com-munity Centre	
Abingdon Elders		2007	12–14	3h	18m	Com-munity Hospital	
Amersham Group		2008	12–14			Friends Mtg House	
High Wycombe Group		2009	12–14			Friends Mtg House	
Milton Keynes mini-TC		2009	20–24	2d	18m	Com-munity Centre	With Border-line UK
Diverse Pathways, Leeds	TC Services North (TCNS) + MH Trusts ± Local Authorities	2004	12–16	1d Mo n		MHT comm service	
15, Manchester		2004	9–15	1d Mo n	12m	Psycho-therapy Dept	Poss 12m agreed
Rotunda, Liverpool		2004		1d		Com-munity Centre	Local Author-ity

Mini Therapeutic Communities	Parent organisation	Starting date	Number of members (normal - max)	Days (hours) per week	Length of programme	Premises	Notes
North Pennine DTC, Oldham & Bury	TC Services North (TCNS) + MH Trusts ± Local Authorities	2008	7-15+	5½ h Thu	12m	Vol on old MH site	
Taste, Stockport		2007	10–15+	1d Tue	12m	Com-munity Centre	
174, Bolton		2007					Close integra-tion
2B, Blackburn & Burnley		2008					
Aspatria Itinerant TC	N Cumbria PD Pilot & MHT	2004		2d		Rugby club	
Barrow/Kendal Itinerant TC		2009		2d		tbf	
Mandala, Worksop	Notts PDDN & MHT	2005	2–8	1½ d	18m	Mind premises	Re-launch in 2008
St Andrews, York	MHT	2007	12–16	3½ d	12m	Psycho-therapy Dept	In PCT
Bridger House, Birmingham	Main House & MHT	2006	12–16			PD service OP dept	
Jasmine Centre, Leicester	FDL & MHT	2006	8–10				Women-only

Mini TCs tend to operate on the same principles as 'normal' TCs (meaning residential and day TCs): they provide a living learning experience through regular community meetings at which all members are present, and would normally meet the core standards for therapeutic communities as set out in the Service Standards for Therapeutic Communities (2005), with the exception in some mini TCs of core standard 4 ('All community members share meals together') and subject to some limitation in standards 2 and 6, both of which relate to sharing day-to-day tasks and living together, due to the limited amount of time members are together and, in some mini TCs, the restricted facilities available. In this context of the experience of shared living being less prominent, the issues dealt with in community meetings tend to be those that arise in the more limited contact the members have together, for example in the tea breaks, while eating a packed lunch together, or while smoking in

between sessions. A relatively larger proportion of material originates from the operation of the support system.

The Thames Valley Initiative

TVI, the PD project in the Thames Valley, was the largest of the successful national PD pilot sites, covering Berkshire, Buckinghamshire and Oxfordshire (Diagram 1). Much of the recent work around mini TCs has occurred in the Thames Valley, in an attempt to provide TC services to a wide range of people scattered over a large area. The Thames Valley has a population of 2.2 million in mixed urban and rural communities. The pilots were commissioned in 2004 as part of the National Personality Disorder Development Programme which arose following publication of the 'Personality disorder: no longer a diagnosis of exclusion' policy implementation guide (DoH 2003). TVI was heavily influenced by the success of the five-day TC at Winterbourne House (Knowles 1995), which is part of the new TVI organisation.

We felt it important to provide a TC-based model with a range of intensity of interventions; so we devised a model with a mixture of five day, three day and mini TCs, and also a geographical spread not just restricted to the three main towns of Reading, Oxford and Aylesbury. So for example in Oxfordshire, there are mini TCs in the north, west and south east of the county and a five-day TC in Oxford city (which is at the geographical centre of the county). Similar plans are anticipated for more locally accessible services in Berkshire and Buckinghamshire.

This open accessibility has been vital to the development of the services – self-referrals are not only accepted but encouraged, and the various TC services have been placed around the counties, either at transport hubs or in centres of morbidity, to help as wide a population as possible to be able to get to them. As part of the development of the TCs, the teams have worked hard to make links with commissioners, referrers and both statutory and non-statutory partners. Non-statutory partnership is a prominent part of this development, and initially included partnership with Mind (a UK mental health charity), floating support teams and latterly with Rethink (another mental health charity in the UK, with whom we carry out 'Family and Friends', sometimes known as 'Carers', groups) and mental health employment charities who partner us with our 'back to life' (tier IV, see below) programmes.

The only way it has been possible to roll this programme out in such a short time and in such a comprehensive way is by keeping commissioners, including Primary Care Trusts, the Strategic Health Authority and the National Institute for Mental Health for England (NIMHE, now part of the Care Services Improvement Partnership, CSIP) , very closely connected with developments, at the same time working hard at building close links with local clinicians and putting an emphasis on being responsive and helpful to them when they request help, a not infrequent event. Doing this in partnership with others – several others, including those outside the NHS – has been a key factor in receiving and maintaining support. The other piece of political work that has been central to

the success of this initiative has been keeping in close contact with the executive boards of the NHS Trusts involved, who have mostly been supportive, and at various important points have been instrumental in allowing the initiative to get off the ground. Those in leadership roles in the project have put a lot of effort into this relationship building to ensure that the people in positions of power, and those who hold the purse strings, understand the issues involved in this kind of work.

TVI model of service delivery

The model works on a geographically distributed and functionally tiered basis.

- Tier I is 'assertive or facilitated engagement' and includes options groups and link groups, which are a gentle introduction to the methods of TC working, and which sometime involve individual work alongside the introductory group work. This was originally modelled on the Winterbourne TAC (Tuesday Afternoon, or Assessment, Community) group which started in 1997, and typically involves an opening community group, an activity such as a game, and a closing community group, all chaired by members, the whole generally lasting no more than a couple of hours once a week. Tier 1 also includes Family and Friends groups, consultation groups for professionals, and now includes much ex-service user involvement. Most of the tier I groups are led by 'experts by experience' or 'XBXs', and all have input from them. This parallels practice in the addiction TCs, which have routinely employed ex-service users for some years.
- Tier II comprises the mini TCs. There are at present three in the Thames Valley, with two more under development. They all have slightly different structures and procedures, depending on where they have grown and what specific skills and personal attributes the staff bring to them; for example some incorporate individual work as described below in the Wallingford group, others use only group meetings.
- Tier III is the day TCs; a three-day TC in Aylesbury for Buckinghamshire, and five-day TCs in Oxford for Oxfordshire and at the long-standing Winterbourne TC in Reading for Berkshire.
- Tier IV is a step down 'back to life' tier, to avoid the 'cliff edge effect' at the end of TC therapy. It involves a group which members attend for the last few months of their time in one of the TCs, and for a few months after they have left the intensive programme. The groups bring together members from all of the TCs (mini and day) in any one county. They emphasise a return to education, training or work, and use a solution-focussed approach in an open style which is not exploratory or confrontative in the way the tier II and III groups often are. STARS (Support, Training And Recovery System) and representatives from outside agencies (such as employment and welfare agencies) contribute to the programme.

Service user and ex-service user involvement is central to the success of this model, and following a successful exit from treatment there is a career pathway

for service users, along with an evolving set of wellness criteria that define the required levels of functioning for various activities. These ensure that they are capable of fulfilling the teaching, consultation, training and group facilitation functions for which they offer their services as consultants – and for which they get paid. This is called the STARS programme, and it involves a career progression from 'Service User' (SU: where such work is only undertaken as part of the clinical programme) to 'Ex-service user' (XSU: normally after a period free of therapy) to 'Expert by Experience' (XBX: for which particular capabilities are required), helping with the work of the TVI on a consultancy basis. For those who are interested in more substantive work, which has so far included XBX Researchers, Assistant Team Therapists and Team Therapists, Training Associates, and Development Workers, we are committed to employing whomever of them we can. There is a small budget and carefully devised pathway to employ people – mostly part-time and mostly on fixed-term contracts, within in the NHS, explicitly as stepping stones to working in regular ways.

The TVI development is divided into four local teams: the three county teams, which are primarily expected to deliver clinical services, and an 'umbrella' team which takes the lead on training, research and development. Training is a high-profile part of the development; the entire project is closely linked into the National Personality Disorder Development Team at the Department of Health, and to other emerging national PD projects such as the Personality Disorder Institute with its role in developing knowledge and understanding frameworks for the field, and Personality Plus, is a service user-led project to reduce stigma through the use of creativity and art.

The Wallingford Group: a mini TC

As an illustration of this work, we will present details of the 'Wallingford group', a mini TC which has been running for almost four years (since before the Thames Valley Initiative was a successful bidder for national PD funding). The initial two TCs in Oxfordshire were both mini TCs, one in Oxford and one in Wallingford, and were started on goodwill and a very small budget of about £36,000 per annum. Most staff were seconded from their teams, as a developmental or learning opportunity, and without any replacement funding for the donating teams. The support of the directorate managers and the Trust executive was essential to this process.

Wallingford is a small south Oxfordshire market town with a population of 24,000; south Oxfordshire as a whole has a population of 280,000. Wallingford is not a deprived area, being very pretty and rather affluent – but it was chosen as the location for one of the mini TCs on the basis of extensive consultation with ex-service user groups, and crucially with third sector organisations, who between them have good knowledge of local demography and where transport links work best. So, although Wallingford is not the obvious candidate to place a PD service in terms of morbidity, it is a transport hub. To get from south east Oxfordshire into Oxford you have to come through Wallingford; it has close links with Didcot and Abingdon, both centres of morbidity in south Oxfordshire,

but is also reachable from east Oxfordshire (which would otherwise not be covered by a mini TC).

The model that evolved over the first two years is as follows (Scott & Attwood, forthcoming). There are two once-weekly analytic groups which meet on different days, along with a weekly large group sandwiched between TC opening and closing community meetings. All this is on a Friday morning between 0930 and 1230. Unlike many TCs, all the ones in Oxfordshire take breaks at Christmas, Easter and in the summer; they have out-of-hours peer support (as described in these pages by Higgins 1997, involving members contacting each other at times when the TC is not meeting to provide support and feedback, which is then brought back into the next community meeting), which operates over the group breaks as well, thus maintaining the integrity of the psychological container. In addition to the weekly analytic groups and the weekly large group meeting there have until recently been fortnightly individual sessions, which are mostly administrative, and during which the Structured Clinical Interview for DSM IV, Axis II (SCID II, a PD diagnostic instrument; First et al. 1997), various outcome measurement tools, which are given a high priority in the service, and CPA documentation are administered, and some less intensive therapeutic work is carried out, particularly where members need some help to bring delicate or shaming subjects into the group, and want to think it through in an individual session first. The weekly timetable is summarised in Table 3.

Table 3: Weekly timetable of the Wallingford mini TC

Day	Monday	Tuesday	Wednesday	Thursday	Friday
am				10.45 – 12.00 Small group B	Opening Community meeting - Large group - Closing community meeting
pm		15.15 – 16.30 Small group A			

The staff team consists of three half-time clinicians plus a supervisor, totalling 1.7 whole-time equivalents. The professional backgrounds to the staff working in the group are: a staff grade psychiatrist, a forensic RMN, and a PD community RMN. Between them, they have training in CAT to practitioner level, psychodrama psychotherapy to UKCP level, and the team includes a trainee psychodrama psychotherapist; all are supervised by a group analyst. The staff were recruited not on the basis of these trainings and professional backgrounds, but according to the Personality Disorder Capabilities Framework (Duggan 2002). This gives priority to therapeutic capabilities rather than specific trainings, and in our whole-system recruitment process we also

specifically choose teams rather than individuals. All three of the face-to-face staff attend the community meetings and the large group on Friday morning, two convene one of the small (analytic) groups and one convenes the other small group with the supervisor. The patients are seen for their individual sessions by the clinical staff who are not involved in their small group. Including the opening and closing community meetings, the large group meeting totals three hours on a Friday morning, the small group takes one-and-a-quarter hours once a week, and there are fortnightly 50-minute individual sessions; thus the mini TC consists of a total of just under five hours per week.

The TC timetable consists of a 45-minute opening community meeting, followed by a break during which members socialise, followed by the large group which lasts for 90 minutes. After this there is another break, then a closing community meeting, chaired by members in the normal way. The large group takes a variety of forms, and is planned in collaboration with the members. It tends to run according to the principles of psychodramatic, action methods, cognitive analytic or dialectical behavioural approaches according to current need, informed overall by TC and psychodynamic understandings. The milieu time consists of informal time before and after the meeting, and the 15-minute breaks. A meal is not eaten together, and elements of TC functioning such as shared work tasks are not part of the programme.

People wanting to join the mini TC start in a pre-therapy 'options' group – 'tier I' in the TVI model – of which they can be a member for 12 months. This involves two hours a week of a TC-style group with an activity or game. The previous 'care programme' agreed by mainstream mental health services is usually retained during this period, although some community mental health teams have discharged people once they engage in this preparatory phase. However, care is not formally taken on by the TVI team until they have been admitted to the mini TC and been in it for three months. We place a high priority on constancy in the team (as few changes to staffing as possible). At 16 months people join the step-down process (aka 'tier IV') which in Oxfordshire is a fortnightly group, which overlaps with attendance at the mini TC and continues for two months beyond graduation from it. Research data is collected before discharge, and they are followed up at six months. After this they can get involved in the ex-service user network and the STARS programme

Audit results from the Wallingford Group

Between March 2005 and March 2007, 18 people entered the mini TC, all diagnosed using the SCID II as fulfilling two or more criteria for personality disorders. One left the group after two months, and one was discharged from the group using the normal TC democratic process. During this period there were seven planned exits. This represents an 80% retention rate. Service use decreased across the board (Table 4) as did symptomatology and risk; function and wellbeing measures, as measured by the Clinical Outcomes in Routine Evaluation questionnaire (CORE; Evans et al. 2002), increased (Table 5). It should be noted that these results are for members at point of discharge from

the TC and represent small numbers; data for service use following graduation from the TC are not yet available.

Table 4: Service use, symptomatic and functional improvement in the Wallingford group, successful completers (n=7)

Service area	Annual prior to joining the group	Annual at exit from the group	Reduction
GP attendance	100	30	70%
CMHT attendance	172	4	97%
Psychiatric admissions	138	4	97%
Suicide attempts	3	0	
Self Harm episodes	82	10	88%

Table 5: CORE results for successful completers of mini TC treatment (mean figures, n=7)

Domain	Wellbeing	Problems	Functioning	Risk
Entry into Therapy	10.4	28.9	23.3	4.1
Exit from Therapy	2.7	10	5	0.1
Improvement	74%	65%	79%	97%

Conclusion

In the UK the new commissioning environment poses a threat to long-established services, and there is an emphasis in public policy on modernisation with accountability and governance, accompanied by flexibility and innovation. Although we have not mentioned all the TCs which have not survived into the 21st century, we have shown how adaptation to the commissioning environment can mean TCs survive and thrive. These new developments may not fit neatly into traditional conceptions of what TCs look like. We have demonstrated in this paper how a willingness to be flexible in terms of the models used (in terms of intensity of the work), the willingness to prioritise data collection and analysis, and a political awareness of the commissioning environment all make it possible to preserve and expand provision.

It would be an unforgivable omission in our generation if we were to let the humane, compassionate and democratic principles of TC work be diminished or degraded in the turbulence of the current forces of globalisation and competition. In order to uphold the values of TCs, which should include spontaneity, adaptability and creativity, we must work together with each other and whomsoever else we need, to preserve the principles we hold to be essential for meaningful therapy.

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Maintaining Hope While Under Threat

David Walker

ABSTRACT: This paper will explore the impact on staff attempting to maintain and protect a long-term medication-free community for drug abusers within a health service setting. The author will describe the chaotic external context, its effect on the community and its staff group.

There are many chaotic external variables, which include: changes in the legal framework, the community moving under health service management, restructuring of host services in mental health, and confusion and rivalry between different organisations providing services for drug abusers.

It is suggested rapidly changing and uncertain circumstances are now commonplace. How to survive and work effectively in such circumstances is crucial. The author will explore the despair caused through external chaos and how it is possible to maintain hope in such circumstances to maintain high quality work. Drawing from group analytic and complexity literature, the paper will suggest an approach to understanding the turmoil within a therapeutic organisation and its surrounding context. It is proposed that such understanding may be of benefit to staff working in such circumstances.

Story 1: Resignation or not

I wake up depressed. It is a Tuesday morning in February. It is raining with low cloud hanging over Bergen's surrounding mountains. My second winter in Norway. The rain adds to the northern darkness, which will clear into vague gloom about 10.00 am. I struggle to get up, thinking about the meeting ahead. The leader team at Floen has five members: the overall leader, I as clinical leader and our three team leaders. This morning we have leader team supervision with an external consultant. I am wondering whether I shall tell them I am thinking of leaving Floen, frustrated by some of the chaos around us and not wanting to change how we work.

It is 9.00 am after coffee and muffins in a café by the quay; I am feeling a little more cheerful as the meeting begins. My boss starts and says: 'I think I

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need to tell you I have applied for another job.' One of the team leaders follows and says that she has also applied for another post. Neither know if they will accept the posts if offered them. A second team leader tells of her worry that she will have to take a long period of sick leave due to a recurrence of an old back injury. What is happening?

I think as a leader team we had lost our hope and motivation to continue. This was for a combination of personal and professional reasons for all of us. We were feeling understaffed, under pressure, the management structure above us was uncertain, and we had been through a year of doubt about our future. As individuals, of course, we had our own personal issues: for me emigration and immigration was still a struggle, as was language. Now, we had to prepare for an external health service quality inspection which we did not see as a priority but demanded time.

Three months later in a leader team meeting, we are discussing some pupil dropouts from the community 'I think we lost our sense of priority.' I say. 'We had too little time to pay attention to clinical matters. We could not support the milieu therapists to hold the pupils. There were too many different agendas and too much chaos.'

I think as the leader team we were struggling with external chaos and doubt about the community's future, and this interacted with each individual's own sense of personal/professional identity. Struggling with this meant that there was less time to be with front line staff and pupils, and it was harder to stay with their internal chaos which in turn led to dissatisfaction from staff and to pupils dropping out more quickly.

Core theme of this paper

Hope is necessary to be able to move forward in life and work. It is essential in enabling one to continue to function and move through moments of uncertainty. Uncertainties together with chaotic and often conflicting circumstances are now the norm for many in modern organisations. The nature of our work is to do with illness, disease, disability, abuse, madness and death. Many of the conditions or illnesses encountered do not have ready cures or easily understood causes, despite the evidence-based culture which prevails. This means clinicians and managers have to make decisions without having clear answers for presenting problems. The culture is increasingly one of evaluation and performance measurement, and in this context professional groups are criticised and undermined.

This combination of the nature of the work, the surrounding dominant discourse and the chaotic circumstances within organisations can easily threaten both individual workers and therapeutic communities, leading to loss of hope. Threats can be internally or externally generated, perceived or real. Loss of hope leads to despair and difficulty moving forward. Thus, despair grows out of threat but also adds to it. To survive it is necessary to maintain hope in the possibility of moving forward. This can be helped through paying attention to one's experience and taking this experience seriously; developing

an understanding of the processes occurring; developing a theoretical understanding of organisational life which is consistent with one's experience; maintaining connections and changing the conversations; working in the present moment.

Introduction

When beginning this paper, I was in the middle of despair and wondering how much longer it was possible to survive in my current working life. Would the community survive and how much longer would my senior colleagues resist the pressure exerted on them? I used this paper in an attempt to do several things:

- clarify my understanding of chaos, hope and threat;
- describe something of my current work situation;
- try to make sense of this;
- draw tentative conclusions about how to go forward as stimulus for further thought.

I will argue for an understanding of an organisation as consisting only of relationship and that it is important to pay attention to the relational aspects within organisational life addressing emotional and unconscious processes. I will emphasise the importance of anxiety and power in these relationships. I note the importance of the present and the reality of messiness and chaos. Finally, I argue for the need to take one's experience seriously, noting that I can only change myself not the other.

My current work situation

Background

Floen Kollektivet is a drug-free therapeutic community in Bergen, Norway, where I work as Clinical Leader. It is part of the National Health Service provision in Bergen. The community is for young people between the ages of 18–30 at first admission who wish to work towards becoming drug free and changing their lives and themselves. We work with some 20–25 pupils in residential treatment and many others pre- and post-residential treatment (we use the term 'pupil', not 'patient').

There are three main treatment stages. In the first, pupils live, work and have therapy on a farm in a rural setting on a fjord in western Norway. Second stage pupils live in staffed accommodation more independently. Finally, they are supported as outpatients while they live independently. The whole process can take from three to five years, throughout which pupils helping each other is an essential part of the process. Pupils are expected to be drug free during all phases but of course do break down, drop out and use drugs. If this happens staff will keep regular contact with them until they are ready to return to treatment.

Currently we are negotiating to develop a day treatment centre to work with more patients pre- and post-community, to enable some to move through the residential phases quicker, and to provide a therapeutic community approach for those unable to enter residential treatment.

External world

I will try and give a picture of some of the external changes and chaos.

1) Floen was transferred into the health service from social services in 2003. Previously the leader had a direct relationship to the commissioning body. Now there are at least four levels between us and the commissioning body.
2) Floen was transferred into health because government legislation in 2002 was passed which meant services for drug users should be classified as health and not social services. Public organisations had to transfer to health institutions while private ones had to meet health rather than social service criteria. This change meant:
    a. people with drug problems had the same rights of access to health treatment as other health problems, which included access to multi-professional assessment, and allocation to treatment within a certain time;
    b. the institution had to meet health requirements;
    c. staff were seen as health workers so had to meet the necessary training, educational and salary conditions;
    d. pupils were officially patients and all had to be given diagnoses.
3) Rivalry and confusion between drug provider agencies. There are a number of private providers of drug services in the area, and little cooperation at management level.
4) There is no agreed policy or model for the provision of drug services in Bergen. A series of meetings in 2006 to develop agreed policy and prioritise a way forward finally broke down amidst anger and mistrust. During this process, Floen had to defend its model and approach.
5) Political policy can favour maintenance treatment rather than drug-free treatment, especially as a relative of a senior politician receives maintenance treatment.
6) Changes in senior management within the health service may lead to different policies related to funding private providers.
7) Floen is managed through a section of the psychiatry services and there is much change in the structure of these. Services for drug misusers are not viewed as a priority.
8) Long-term sickness of managers in psychiatry responsible for Floen has led to lack of representation.
9) Boundary issues. Bergen is a relatively small community, population about 230,000 with another 200,000 served by services in Bergen within 1–2

hours' driving time. The next large town is over four hours away. There is intermingling, people know each other. Friends work for rival drug organisations. People cannot easily move to new jobs.

10) A recent quality inspection by the National Health Service inspection body criticised our documentation, and adherence to health service procedures.

So these are some of the external pressures and confusions that are around. That is without commenting on some of the pressures from pupil work, or the daily problems of ensuring we have and keep enough competent staff and increase our establishment to match growing work demands.

Story 2: Growth or closure

In a sense the above descriptions are all very factual, and do not illustrate the effect that such chaos has on staff. What is the emotional impact? I think my opening story illustrated something of this. Let me describe another.

I am meeting to supervise a recently appointed member of our intake team who has to liaise with the private institution over admissions. 'I need to be kept informed of what is happening,' he irritably demands. 'I think I should be part of Floen's leader team. You need to keep me better informed. At the intake meeting with X on Thursday, they told me it was announced at the regional meeting last week that Floen was getting three new staff and taking more patients. Why didn't I know? It feels embarrassing to be told about your organisation by someone else.'

I immediately feel irritated by his demanding manner and his assumption I had done something wrong. I feel he does not understand the complex political situation. It would be easy to fight with him, especially as we are still establishing a working relationship.

I wonder aloud why he cannot trust me, and tell him that at times he may have to deal with embarrassing situations at the intake, especially given the political context. Then, in a more conciliatory manner, I try and explain something of the chaotic situation. 'We are managing a great deal of uncertainty and the political situation is changing every day, and we are thinking always about how much to tell staff and when. The previous week, we thought we may be asked to change to short-term treatment, including medication; however, after two meetings, we were hopeful we could continue with our model. Then it was agreed we would be given funding for three more staff. This decision was announced by an administrator at a public meeting I think for political purposes. When we tried to advertise these posts we were told there was no funding. We are still trying to resolve this issue.'

So the external uncertainty and chaos around funding and decision making within the organisation leads to embarrassment for staff at the interface of Floen, irritation between senior and junior staff, doubt and frustration about communication, and a sense of powerlessness. It requires time and emotional energy to explain and resolve these issues or serious internal tensions will develop and undermine the work with pupils.

Some definitions

I am suggesting there is something about chaos which causes a sense of threat and a loss of hope, thus leading to despair. I think it important to pause a moment and explore something of what we understand by the terms 'chaos', 'hope', 'despair' and 'threat'.

Chaos

Chaos or a state of utter confusion and disorder can have many different causes, which include: the nature of the work (drug addiction); a changing external world; conflict between perceived tasks (cure or maintenance, meet budget or treat patients); conflict between theoretical models and approaches used; conflict between lived own experience and the external take on the world (mismatch between dominant discourse and the reality of an individual's experience) (Stacey 2006); distorted and muddled communication (Hinshelwood 2001); threats to identity (individual and group); complexities of everyday relationships.

Threat

The OED defines threat as:

1. oppression, compulsion; torment; distress, misery, danger;
2. a declaration of an intention to take some hostile action; esp. a declaration of intention to inflict pain, injury, damage, or other punishment or retribution for something done or not done. An indication of the approach of something unwelcome or undesirable; a person or thing regarded as likely to cause harm.

Threat can be an external actual reality or an internal imagined state. I think it is helpful to view threat as an intersubjective process occurring between people through the application of power and the experience of anxiety. Whether an external event is perceived as a threat or not may vary according to different factors. Threat can vary both in terms of size and intensity. Factors that decrease or increase the sense of threat I think include: the presence or absence of a peer reference group; the level of anxiety; the type of power relations and power configuration; the number of events; the sense of connection or lack of connection to others, both internal and external to the community; the past history and patterns, both individual and community.

Threat can be both physical and psychological. Physical threats include: closure; merger or takeover; downsizing; change of function; enforced changes of treatment model; loss or change of physical surroundings; reduction in staffing; budget cuts. Psychological threat can be through: loss of identity; challenges to identity; lack of recognition (not being seen); loss of meaning; pressure to prove oneself; shame or public humiliation; powerlessness.

Anxiety

Being under threat elicits an emotional reaction which can include anger and rage, a sense of betrayal, anxiety and fear, despair, self-doubt, depression and a sense of loss. Responses can include various versions of fight or withdrawal or stoically carrying on. I suggest anxiety is particularly related to threat and the loss of hope. Traditionally anxiety can be seen as either pathological, that is an abnormal condition associated with illness, or as a normal reaction to unusual events. However both these positions imply it is possible, theoretically at least, to have an anxiety-free existence by avoiding illness or abnormal events. I argue anxiety is an inevitable and essential aspect of human relating.

Glas (2003) suggests three traditions in the study of anxiety. The first, the medical tradition, favours a biological approach to anxiety. The second, the psychoanalytic tradition, views anxiety as being the result of inner threat. Existential anxiety is seen by Glas as the third tradition of anxiety, in which anxiety is seen as a response to more fundamental existential concerns related to existing in the world, 'the meaning of life'.

I have found the concept of existential anxiety important. Tillich (1952) makes a distinction between pathological anxiety and existential anxiety, claiming pathological anxiety occurs when the individual is unable to take the existential anxiety upon him; by this I understand Tillich to mean that the individual is unable to cope with the implications of such anxieties.

Tillich (1952) has developed an ontology of anxiety proposing three forms of existential anxiety. This analysis of anxiety is helpful in exploring some of what happens when under threat. Tillich describes the anxiety of fate and death; biological extinction is a fact we are all dimly aware of and our community may not survive. He describes the anxiety of emptiness and meaninglessness; the meaning of the work we do is questioned and there can be a search for definite structures to deal with doubt. Finally he describes the anxiety of guilt and condemnation; the individual struggling with a sense of what he has made of himself and how he will be judged, a key issue for those in communities under threat, also for leaders of such communities who question their own performance and if they could have done more to protect their service.

In particular how we manage the anxiety of not knowing, the anxiety of knowing and the anxiety of staying in the moment is important. I think these can all be understood as aspects of existential anxiety which we encounter in our everyday relating in chaotic organisations and which have important implications for the maintenance of hope. These aspects of existential anxiety have to be recognised and survived somehow.

Hope and despair

The OED defines hope as 'Expectation of something desired; a feeling of expectation and desire combine'; and despair as 'Complete loss or absence of hope; hopelessness'.

Casement (1985), when writing about projective identification, suggests there is unconscious hope implied in the use of projective identification as communication; hope that the other will recognise and respond to the unmanageable feelings projected out. If the recipient cannot manage this, then 'the sense of these feelings being unmanageable is traumatically confirmed' (1985:82). He states: 'Instead of the unconscious hope being met, there is a new state of hopelessness and despair.' There is despair about never being heard or seen. When this occurs, loss of hope in ever finding what is needed leads to attempts to achieve gratification in other ways.

This of course is a crucial component within the genesis of drug addiction. This reminds me of the roller coaster ride I recently experienced as to whether Floen would be supported and developed further or not. There was hope of real growth, as well as unconscious hope that someone in authority would respond to requests for clarity about our future. When, yet again, there was not a clear message back, it felt as if our wish to be understood and 'held' was not heard. The optimism and hopefulness quickly turned to despair at these moments of repeated uncertainty and 'failed understanding'. (I think this experience of not being heard and subsequent loss of hope almost led to the leader team changing jobs in story 1 and the frustrations in story 2.)

Yalom (1985) lists the 'installation of hope' as one of the curative factors of group psychotherapy. Hope is crucial in the early stages of treatment to allow connection and avoid dropout. Indeed hope gained from seeing other ex-addicts who have made it is an important factor at Floen.

Pines (1998) writes about the importance of meaningful dialogue between mother and infant. He suggests that the installation of hope can be seen as the insertion of meaningful dialogue between group members or patient and therapist. He suggests hope is a strong counter to self-destructive attitudes and despair but has to be based on 'a well-grounded foundation of learning and experience' (1998:80).

Hopper (2003) further explores the nature of hope. He defines hope as 'desirous expectation', drawing a number of distinctions. 'Hope always implies a belief in the possibility of improvement and creativity, that is, in the possibility of making something better and something new.' 'Hope always implies a kind of paradox: on the one hand that the desirous expectation has not been realised; but, on the other, it has met with some degree of success.' Hope 'is directed to the future but based on past experience.' Hope can be either mature or infantile. Hope can be conscious or unconscious. He develops a view of hope based on object relations thinking. He argues

> the infant is born in a state of primary love for, and harmonious confusion with, his mother, but in a state of great vulnerability and dependency, within a social, cultural and political context which both facilitates the choice of goals and the achievement of them, and presents obstacles to the achievement of objects of desire. Thus the traumatogenic process is ubiquitous, as are frustration and aggression. However, the extent and intensity of traumatic experience are indeed variable.

> Within this context, I would define hope as the willingness and ability to exercise transcendent imagination in an attempt to overcome obstacles to the fulfilment of desirous expectations. (Hopper, 2003:203)

He continues to say that this process is dependent on levels of safety and working social groupings, within which there are optimal conditions of authority and power. I would also add anxiety.

Levine (2007) draws a distinction between hope as a source of optimism or despair. Mature hope based on good internal objects and a stable sense of self as contrasted with idealised hope when internal objects are bad and consequently the sense of self is weaker. She argues idealised hope can be positive, allowing for relationships to develop with the external world or malignant as the search for the ideal blocks any contact. Somehow we have to be realistic about what is possible rather than maintain an unreal idealised vision of how therapeutic communities could develop, and we have to work to develop manageable conditions of authority, power and anxiety.

Story 3: Fighting with management

I feel the hope drain out of me almost as if someone had pulled out a plug. I sit back in my chair and decide to take no further part in the conversation. We are meeting with a health service line manager to discuss the report we have to send back to the quality inspection organisation after their critical report of us. Previously I have had a good relationship with this manager and had felt positive about this report, thinking we could use it to improve our services.

This is the third meeting we have had. Each time I have left feeling drained, irritated, hopeless and depressed. This occurred after I started becoming irritated with the manager and fighting with him. I realised I do not feel that either me or my senior colleague have been seen or heard. We have arrived at previous meetings having prepared reports which have been criticised. I feel undermined and disrespected as I do not feel understood or taken notice of. I feel I am being told what to do, and sullenly resent this. I think the manager's overload, and guilt about not being available for us, lead to us receiving instructions about what to do rather than help to do it. I find my hopelessness and despair increasing and become more resistant and tired at the prospect of having to meet the government agenda.

I feel we have different ways to understand the quality task before us. I am reminded of Stacey's critique of the current model of public sector governance. He comments on research which shows the level of stress and sickness in public sector workers partly due to emotional demands and negative public attitudes. He thinks that a 'significant factor in the growing emotional demands relates to the model of public sector governance, which is undermining any sense of vocation, and leading to depression and feelings of alienation from one's own experience' (2006:25). This is how I feel; somehow my experience is made to feel invalid.

Later, I interrupt the meeting and wonder why we always end up fighting. I change the conversation and we are able to talk honestly together about our respective frustrations and anxieties. Binney et al. (2003) write:

> A key challenge, therefore, for leaders and the people around them, was somehow to hang on to their dreams while engaging with the here and now. Paradoxically, the focus on setting vision and direction – intended to instil a positive, forward looking mentality – could leave people compliant, resentful and paralysed. It was by beginning to name uncomfortable parts of current reality that energy was released and people could look forward. This tension was truly at the heart of leadership transition: the more leaders could live intensely, in the moment, and let go of the anxiety to impose themselves on events, the more effective they could be in leading change. (Binney et al. 2003:77)

Let me reflect a moment further on anxiety and what was happening in the above situation. Williams (2006) has written about the experience of leading in public sector organisations in today's performance management regime. He argues this performance orientation has provoked deep feelings of ontological anxiety. He argues this anxiety configuration is the defining context of work in public sectors today. He suggests the current work ethic is one in which 'ontological security is contingent upon one's ability to sustain a performance of success in a context which does not admit the possibility of systemic policy failure but which localises the causes of underachievement in the personal capabilities of individual unit managers' (2006:72). By ontological security I understand Williams to mean confidence in one's sense of being and identity; to put it simply, safety in one's sense of self. If one's identity is continually undermined through current interactions which are influenced by dominant discourses, then one's sense of self can be seriously threatened leading to profound anxiety.

I think this was affecting both me and my managers and fuelling the arguments and irritations. We felt personal insecurity in the circumstances of our professional work being questioned and without it being possible to take account of all the reasons for the failures. My sense of belief in what mattered and the validity of my experience in the work was being challenged and made to seem invalid. This contributed to a sense of threat and loss of hope in being understood or being able to create meaningful dialogue together.

I am arguing that to maintain hope we have to have a way to make sense and understand what is happening. We also have to begin real conversations in the right context about our experience and the emotionally laden difficult issues which are normally not spoken about.

Complex responsive process as a way of understanding organisation

I find it helpful to distinguish two different ways of understanding organisation and human interaction. The first is based on a systems understanding. An

organisation is a system which functions according to certain principles; if we as leaders can understand this we can alter the system from outside and move it towards our goals. In the same way, this way of understanding can be used in human interaction. If I understand the other well enough I can do something to change them. From this approach much work goes into vision, strategy and intervening to move person X or organisation Y from A to B. This approach underlies much of mainstream understanding of organisation (Senge 1990).

The assumption suggests that a skilled leader can know the future and plan for it. In the earlier stories we were struggling with the notion that we as leaders, and our own leaders, should somehow have known the future, the workings of the system and how to intervene. As Griffin (2002:206–207) explains, a systemic self-organisation perspective relies on a linear notion of time so the future can be split off and planned for by leaders. As a good leader, I should have been able to prepare the member of the intake team in story 2. At the same time the systems approach presents a dual causality as the origin of change lies not within the system but outside it. The leader is outside the system able to influence the direction of other lesser team members.

I have begun to question this understanding. I find a complex responsive process approach to understanding organisation helpful. From this perspective all that exists is the relationships at any one time. Complex responsive processes is a way of understanding human relating and human organisations, which has drawn on analogies from the complexity sciences and has been developed by Stacey and colleagues (Stacey et al. 2000; Stacey 2001; 2003). I have found this way of understanding organisations to reflect the reality of some of my experience as a leader (Walker 2005).

> From the perspective of complex responsive processes, organizations are thought of as patterns of interaction between people that are iterated as the present … Organizations are understood as processes of human relating, as the simultaneous cooperative-consensual and conflictual-competitive relating between people in which everything organizational happens. It is through these ordinary, everyday processes of relating that people in organizations cope with complexity and uncertainty of organizational life. As they do so, they perpetually construct their future together as their present. (Stacey 2006:4)

From this perspective, human relationships are seen always as complex, self-organising and emergent, and evolving. 'Complexity refers to a particular dynamic or movement in time that is paradoxically stable and unstable, predictable and unpredictable, known and unknown, certain and uncertain, all at the same time' (Stacey 2006:7). I suggest too much of this leads to chaos, too little leads to stuckness and rigidity. It draws on the analogy of 'edge of chaos' in complexity science. Shaw (2002:66–69) explains how this concept first arose from scientists exploring 'the behaviour of computer simulated complex networks of digital symbols or agents'. In their experiments they found three differing patterns of behaviour depending on number and strength of connection between agents, diversity of agents and intensity of information flow between them. There was order or stability in conditions of low

connectivity, low diversity and sluggish interaction; on the other hand, in conditions of high connectivity, high diversity and intense interaction there was disorder. However the researchers found that in some conditions novel complex patterning occurred, which combined both order and disorder. These particular conditions were termed 'edge of chaos'.

A systems approach would suggest that these favourable conditions can be created by the leader, whereas a complex responsive process approach suggests these conditions emerge out of the present moment and the leader has to function within that moment.

Much of our work I believe is spent in trying to change others' rather than our own response. However, if human interaction is understood as a gesture response process, where my response comes from my own emotional/ physiological reaction to your gesture, all I can do is change my own response. If I do this, others may respond differently. But I cannot change your response. If all that exists in organisations is many ongoing different local interactions, then how one responds and manages oneself in these interactions is crucial. Within all such interactions, power and anxiety are crucial variables, so managing our own anxiety and response to power is crucial if we are to survive and maintain hope and influence the outcome of our services.

Another important aspect of complex responsive process theory is the understanding that all that exists is the present moment. Working in that moment is crucial, paying attention to the quality of one's current interactions. Of course reviewing the past and planning for the future is necessary but working in the now is crucial. All I can do is work on maintaining my own hopeful attitude and exploring what my own sense of threat is and how the external factors mediate this. I cannot make others hopeful.

In the midst of chaos, we have to function 'in the moment'. So what is this moment? How can we understand it and what is the connection between the present moment and the past history and or future direction? Much of our work is by necessity connected to past events, for example when investigating a complaint or a crisis which has occurred in the therapeutic community setting. It is also connected to the future; for example, predicting political agendas, staffing patterns or changes in healthcare trends may be important requirements for future success and survival.

Where one pays attention will be determined by one's theory of causality and how change occurs (teleology). Stacey et al. (2000) contrast different forms of teleology as a basis to 'compare different ways of understanding the evolution of human organisations' (2000:51). They use the term 'teleology' to mean two things: the kind of movement into the future that is being assumed and the reason for the movement into the future. Drawing from the complexity sciences and applying this understanding to human organisations, they suggest a transformative teleology is most appropriate as meaning is not pre-determined or future directed. It arises in the present, in contrast to either being in the future or the past, although it arises out of history and is creating future possibilities; hence the term 'living present', which presupposes a transformative teleology. By transformative teleology they refer to a movement

towards a future that is 'under perpetual construction by the movement itself' and is unknown.

In their critique of systems theory they suggest that a systemic view of an organisation is based on a formative teleology, which suggests a movement towards a final known state that can be predicted. This understanding seems at odds with the reality of organisational life. For a further critique of systems theory, readers are referred to Stacey, Griffin and Shaw (2000:56–84) and Stacey (2001:26–30).

Stern (2004), drawing on developments in intersubjective psychotherapy, has developed the notion of 'present moment', which is a concept very similar to the living present of complex responsive process theory.

I think this is important for us and affects how we think and work with chaos. Sense making is important for managing threat and survival, and maintaining hope. Stacey et al. (2000) suggest sense and knowledge arise in the present communications and are not predetermined or passed down. What I believe complex responsive process theory is saying in relation to leaders participating in human organisations is very similar to what Stern is saying in relation to psychotherapists working with patients: that important change develops out of the connections which emerge in the moment-to-moment interactions between people, and paying attention to that moment is crucial. However, this present moment contains within it both past experience and meaning and future direction. It is during this 'now' moment that past events are recalled and re-experienced perhaps, resulting in a different understanding and re-creating of the past. At the same time it is in this 'now' moment that intentions form and are reformed by a future which emerges moment by moment but which does not pre-exist. I think these are very important concepts which I have written about elsewhere (Walker 2006)

Why am I raising these issues? I suggest we need to pay attention to our own experience and emotional reaction and take this seriously. That chaos and continually ever-changing external circumstance are the norm. That relationship is crucial, and power and anxiety are important factors in this which need managing. How we function in the present moment is crucial.

My thesis is that if we can understand organisations in this way it allows us to check and confirm our own experience and feel some sense of autonomy and influence over the way ahead. What becomes important then is not despair about the hopelessness of ever establishing order within the chaos but an understanding of chaos as inevitable and necessary and a working towards an understanding and approach about how to survive or function in this circumstance.

Often as leaders we find ourselves under pressure to give a clear prescription-list of action points to solve the problem. However, this is not what I do in my clinical work, nor is it one of the most useful parts about therapeutic community work. The premise of much group analytic and therapeutic community work is to stay with the uncertainty and explore some of the unconscious aspects which block practical task. Out of this making the

unconscious conscious, or understanding differently, some movement is possible and the practical tasks if needed can be completed.

This I think is one of the problems currently with working in chaotic organisations, that the unconscious-shadow-illegitimate practices-thoughts-feelings that are around are not taken notice of. There is a search for and assumption that order and regularity are there to be found. It is difficult to challenge this. There are a number of dominant discourses which are powerful and run counter to the reality of my experience of organisations and also run counter to my understanding about what is helpful in treatment. Recognising these and changing the conversations around these issues is crucial. Shaw (2002) argues for the centrality of conversation in organisational life and the need to change these conversations. Putting into words what is often avoided is not easy.

Disorderly nature of organisational life and leadership roles

Organisations are messy places; we need to take seriously the complexities and messiness of leading in organisational life. Much of mainstream literature about organisations reads as though proper organisations are ordered well-functioning places. The introduction of methods from private industry into the health service in the UK, and the increasing management, quality improvement processes and performance measurement procedures being introduced into most European health care, are premised on the idea that order can be introduced. There is also a subtle and at times not so subtle pressure on leaders to play the game and pretend order and regularity exist or at least are just round the corner. However lack of order is the norm.

Vaill (1989) describes the ever changing environment of modern organisations as the norm. He uses the metaphor of 'permanent white water' to describe the uncertain, turbulent and constantly unstable environment in which leaders have to function and which creates pressure and anxiety on those in organisations as they attempt to survive. He challenges traditional organisational training and the development of the competency model to management, which suggests sets of ordered skills can be taught. To develop an approach which encourages greater flexibility and improvisation and is an asset to surviving such conditions, he argues it is essential to pay attention to consciousness and self-awareness.

Some mainstream authors, such as Kotter (1982) and Davis et al. (1992), write about leadership as though the leader works with order and clarity. However, this appears far from the reality today. We need to pay attention to the disorderly nature of leadership roles. For example, Binney et al. (2003) talk of the reality of the 'messiness' of leadership and Stern (2004) has a similar idea in relation to the psychotherapist's work when he writes of the relevance and importance of 'sloppiness'. By messiness, Binney et al. refer to the lack of clarity within organisational life including the complex interrelationships, conflicting tasks and ever-changing environment. There is not a present order waiting to be uncovered for which a diagnostic prescription can be given.

Stern's term 'sloppiness' is related but slightly different. He refers to processes of interaction which occur between two people as they attempt to communicate and move forward together. He suggests sloppiness has several characteristics including 'intentional fuzziness', defined as the difficulty of knowing your own or others' intentions; unpredictability; redundancy; and improvisation. He suggests these characteristics of sloppiness have usually been perceived as unhelpful aspects of communication to be eliminated. Instead, he is suggesting these are essential aspects of a moving along process which allows 'unlimited creativity' to occur (Stern 2004:158).

Both terms reflect the reality of organisational experience, and it is important to pay attention to this disorderly experience which can create anxiety. I suggest the ability to see and manage these confusions of everyday life, which occur in organisations and are manifestations of the relationships as well as the 'external' events, is crucial. Working within this reality, rather than avoid it, is essential.

Story 4: Identity and difficulties in thinking

'I am not sure I can continue much longer with the uncertainty about what is happening,' I say to my boss. 'I know I say you have to work with uncertainty but this is too much.' She sympathetically agrees. We need decisions about our future.

I had noticed fluctuations in my mood between hope and despair wondering what affected these fluctuations. While at Floen I felt confident about our work. However, when discussing services with others outside, I felt some despair that others did not really understand. I feared we would be closed down as 'they did not understand us'. However I also knew we had to adapt and become better at explaining our work and integrate more. I think Floen challenges something in the organisation about how we understand and work with illness which can be threatening. How could we think, take part in moving services forward and manage the uncertainty? How could I work with these contrasting views of the world?

As I try to work differently, I have to allow myself time for thinking. As I try to make a different sense of how to go forward, I am forced to think differently, questioning my own mind as well as connecting differently with others. If I am to be effective I have to be able to stay in this anxiety of thinking in the silent private conversation of mind as well as in the public conversation with others. The anxiety aroused by not knowing in these conversations can lead to closing down connections to retreat from a sense of shame about doubt.

Billow, in the context of group psychotherapy, describes how through the group experience 'the individual must endure the process of thinking' (Billow 2003:69). He explores how thinking challenges one's identity and forces a revaluation of one's connection to and meaning of past, present and future. This raises anxieties and causes change in relationships. It is the challenge for us in today's health services to be able to tolerate the anxieties, uncertainties and frustrations. If it is possible to stay with the combined process of thinking

and feeling, rather than move to quick easy but ultimately ineffective solutions, real survival may be possible. Later Billow says:

> Thinking changes one's identity, and hence also disorients and reorients the thinker to past, present and future. The person who bears to think and to learn, risks ever-greater separation from established, conventional relations with others, as well as with one's previous ideas. (Billow 2003:74)

So this process of thinking and integrating new experience, if allowed, leads to a changing sense of connection with self and others. The struggle involved can cause much anxiety and disconnection but, if stayed with, allows a stronger sense of connection, enabling different action. I think if we cannot bear the anxiety and stop thinking this leads to loss of hope.

Conclusion

In this paper I have tried to make sense of the chaotic circumstances around Floen and the effect on me. I explore how the chaos can lead to threat and loss of hope. I suggest to survive it is necessary to maintain a realistic hope. Taking my experience seriously, trying to understand this theoretically, working in the present moment and developing meaningful dialogue consistent with the reality of my experience has helped me survive. I hope some of this experience and the theoretical approach to understanding organisational life may be of use to others.

Note

In this paper I describe some episodes during which I write about and comment on my reaction to others' behaviour. These episodes have either been anonymised to protect individual's confidentiality or, where possible, the individual involved has been consulted with during the preparation of the paper.

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The Price of Permanency: Cost–Benefit Analysis of a Psychosocial Intervention for Children and Families

Barry Jones

ABSTRACT: This paper describes a retrospective cost–benefit analysis of families admitted to the Cassel Hospital Therapeutic Community and reaching two years post-discharge, having received a psychosocial intervention.

Following changes to the legal provision for children and families presenting via Family Courts, there exists an urgent need to quantify the expense and clinical benefits of families that had previously been funded in an assessment and treatment within such care proceedings.

Using Unit costs and through telephone interviews with the funding authority, we construct a cost–benefit analysis of children in care proceedings. We further examine the estimated prospective costs once decisions around permanent placements have been achieved and discuss both the statistical and ethical considerations in funding such interventions. In doing so, we hope to promote a discussion to secure alternative funding alternatives for vulnerable children and families.

Ethical Considerations: Ethical approval for this study was gained from Riverside Ethics Committee, London. All data was stored anonymously with informed consent obtained from each collaborating local authority.

Introduction

The Cassel Hospital exists as a therapeutic community in an open setting. Within it, families present to the 'Family Unit' as a result of concurrent care proceedings, via the Family Courts and with a local authority's involvement. Families are admitted on the basis that the dynamics that threaten the child's welfare require a psychodynamic assessment, together with a formulation of the specific difficulties. Where appropriate, treatment is then undertaken, comprising twice-weekly individual psychotherapy for parent and child alike, family therapy sessions and psychosocial nursing interventions in keeping with

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the principles of a therapeutic community. In turn, this leads to the clinical decision as to whether the family can be 'rehabilitated' back to their local community, or not. Where assessment alone is undertaken, it is with the clinical consensus that the child's welfare is best ensured by future care outside the immediate family. The intervention in all cases, whether assessment or treatment, is principally to ensure that the child is catered for in an environment that will best ensure his welfare and promote his future development.

This retrospective study held several important aims in this regard. Firstly, we hoped to ascertain if permanency had been achieved with regard to the placement for every child receiving an intervention. The central tenet of the Children Act, the welfare principle, states, 'the child's welfare is paramount in deciding all questions about his upbringing ...' (White et al. 1990). A second aim, then, was to ascertain the nature of the child's placement at follow-up and whether their welfare had been ensured by the clinical intervention of the Cassel 'Family Unit'. The number of placements held by children within this period was also of import, as this appears inversely correlated to good outcome for children in care (BAAF 2002).

'On 24 November 2005, the Lords of Appeal overturned previous childcare case law, effectively reinstating the distinction between the medical or psychiatric assessment and the treatment of a child' (Jones 2006). Whereas local authorities had previously been legally obliged to fund both an assessment and treatment of a child, they were now only legally required to fund an assessment. This statement, however, was made without due consideration of the clinical consequences to children and to family life as a result of these funding changes. Subsequent decisions compounded the difficulty in funding. Indeed, it was later remarked that

> The decisions made and resultant proposals represent a significant risk that children's interests and safety will not be properly represented in the care system. This is likely to lead to erroneous and dangerous decisions being made for children and unfair decisions for parents. Will such a process be made transparent to the press and public? (Association of Lawyers for Children 2007)

It did, therefore, serve to focus the need to clarify the costs involved in treatment of children, alongside any benefits, so that the local authority could begin to make informed decisions about providing the funding for treatment of children in care proceedings, their families and their futures. This represents, therefore, the first cost–benefit analysis of a psychosocial intervention for children and families within the setting of a therapeutic community.

The families identified within this study had been afforded the possibility of assessment and treatment under a legal provision, before the law had been changed. This group therefore provided a base from which to examine the issues of funding alluded to in the judgement by the Lords of Appeal. Taken together the knowledge of clinical outcomes and estimated costs of all aspects of the process of a Cassel intervention could be used to construct a cost–benefit

description for admitted families, so that future decisions around funding could be usefully guided.

More specifically, with knowledge of the outcome for each child we could ascertain the costs and benefits for every child, in keeping with the Court's considered deference to the 'welfare principle' of the Children Act, therein placing children centre-stage.

Of course, this path would have limited use without the incorporation of a comparison group, comprising those who had received no such Cassel intervention. In recognition of this, one further aim was to construct estimated costs to the local authority of children where decisions had already been made around permanency, who had been subject to care proceedings and previously placed outside the families before the time of an intervention, but originating from our admitted families.

Method

A) Clinical

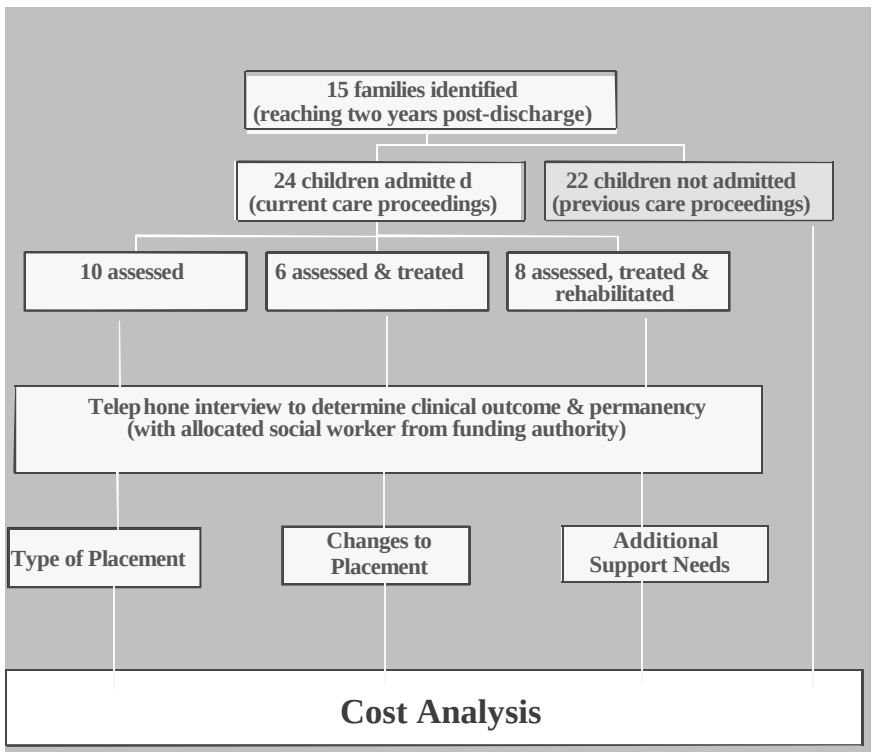
With reference to admission case records, 15 families were identified as reaching two years post-discharge within the chosen year of study, the most recent full year. This comprised all families reaching two years follow-up, with no exclusions. Within these families 24 children were admitted with their families for a psychosocial intervention; 22 children were identified as having been subject to previous care proceedings and were not admitted, having been placed in care before presentation. For each admitted family, the duration of admission was calculated with reference to case records, recorded to the nearest full week. The type of admission was recorded according to whether the family received an assessment alone, or assessment and further treatment. This decision was always taken at the first review (eight weeks). Of those families then moving to treatment, those in which a clinical intent to be rehabilitated were recorded at review were further sub-categorised, to yield three groups in total.

The known status of each family at discharge was recorded. Informed consent was obtained from every local authority and results recorded to ensure anonymity of family members. A telephone questionnaire was then conducted with the allocated social worker. For the period prior to admission, the type of placement and duration in placement for every admitted child was recorded, along with any account of emotional or behavioural difficulties or offending behaviour.

For children not admitted, the type of placement and duration in placement before permanency had been achieved was recorded, along with any account of emotional or behavioural difficulties or offending behaviour. The numbers of changes to placements were not recorded for this group, due to limited access to information by the allocated social worker, given that decisions around permanency had already been reached and cases re-allocated.

For the period of follow-up, the integrity of each family was ascertained through telephone interview (where families had been discharged together), together with the type of placement for the child at follow-up and the number of changes to that placement to follow-up. Where the local authority has made decisions around permanency for the child, this was recorded. Any account of emotional or behavioural difficulties or offending behaviour was also noted for every child. Where the child was of school age within the follow-up period, the type of school and presence of a Statement of Educational needs were noted.

Figure 1: Summary of methodology



B) Cost analysis

Pre-admission costs

For every child admitted, the type and duration of placement up to the point of admission was ascertained to the nearest full week). Where a child was placed in foster care prior to admission, that placement was categorised according to the noted absence or presence of emotional or behavioural disturbance and offending behaviour. Any such placement was then categorised as:

Child in care: low cost – no evidence of additional support needs
Cost to local authority: £36,653 per 52 weeks

Child in care: medium cost – children with emotional or behavioural difficulties
Cost to local authority: *£33,217 per 52 weeks[1]

Child in care: high cost – children with emotional or behavioural difficulties and offending behaviour
Cost to local authority: £226,620 per 52 weeks

(Unit Costs of Health and Social Care 2006)

Knowledge of the duration in placement for any child in foster care, prior to admission, thus afforded an estimate of the cost of each child in a categorised foster placement up to the admission point, together with an estimate of the total cost per family with any children in foster care and presenting to the Cassel service.

As every child was also subject to Family Court care proceedings, the application of a care order by the local authority had been made for every child prior to admission. The cost of the making of a care order was thus incorporated into pre-admission costs to the local authority for each child admitted – £25,000 (Department of Constitutional Affairs 2006).

The estimated costs per family up to the point of presentation and the costs per admitted child to the point of presentation were thus calculated.

Admission costs

The cost of admission per family was calculated by the Cassel finance department prior to billing of the local authority and based on the number of children and duration of stay. The costs of maintaining any foster care placement for the child for the duration of admission (a frequent recommendation) was also noted, having been categorised as in the pre-admission period.

Together, these costs were taken as the cost of each family for the admission period to give a total sum estimate.

The average cost of admission per child was then calculated by dividing the total sum by number of children. Costs of parents to the admission process were taken as a function of the cost of addressing the child's environment and thus of the child.

Post-discharge costs

Where a family had been rehabilitated home and had remained there, in the absence of additional support needs, the additional costs to the local authority were recorded as zero.

[1] Medium costs to the local authority are lower than low cost placements as additional costs here begin to be borne by other agencies, including agencies and health, thus forming a greater total whilst with less expenditure to the local authority.

Where the family had not been rehabilitated together, or the rehabilitated family had broken down within the follow-up period, the type and duration of placement of any child in foster care were categorised as before and estimated costs obtained for each child placed till the time of follow-up.

Where the child had entered into an adoptive placement, the costs of the adoptive process (£12,075), of maintaining the child in the adoptive home until the making of an adoption order (£6,092) and the cost of post-adoption support (£2,334 per 52 weeks) for the follow-up period were obtained (Unit Cost of Health and Social Care 2004).

Where the child had been placed with an extended family member, designated as a Special Guardian, the costs of that placement up till the point of follow-up were calculated as part of the post-discharge costs (Government Special Guardianship Regulations 2005).

Projected Cost Comparison

Where permanency had been achieved for an admitted child, i.e. the child had a permanent residence of stable cost (and knowledge of the child's age at the time permanency was achieved), a projected estimate of the child's cost to the local authority, from the point of contact to the point of their 18th year, could then be calculated.

Similarly, for children not admitted and subject to previous care proceedings, the type and duration of placement before permanency afforded a categorisation[2] and costing of children in foster care until permanency had been achieved, as described above.

With permanency achieved for these children and with knowledge of the time in care until their 18th year, projected costs were obtained for each of these children from the point of contact to the local authority until their 18th year. This afforded a comparison between Projected Costs to the local authority of those children admitted versus those not admitted, up till their 18th year.

From the sample under study, in combination with the clinical outcome data with regard to the percentage of children remaining as a family and of those requiring no additional support needs, a cost–benefit formulation could then be drawn for children admitted.

The outcome measure, cost, was measured on a numerical scale. There are two possible tests that can be used to compare a numerical measurement between groups. The first is the two-sample t-test. However, an assumption of this test is that the data is normally distributed. A second test is the Mann-Whitney test, which makes no assumptions about the distribution.

An examination of the distribution of the cost measurements indicated that they were skewed, with more small costs, and fewer higher costs. However, with cost data sometimes the total cost is often the most important issue, especially

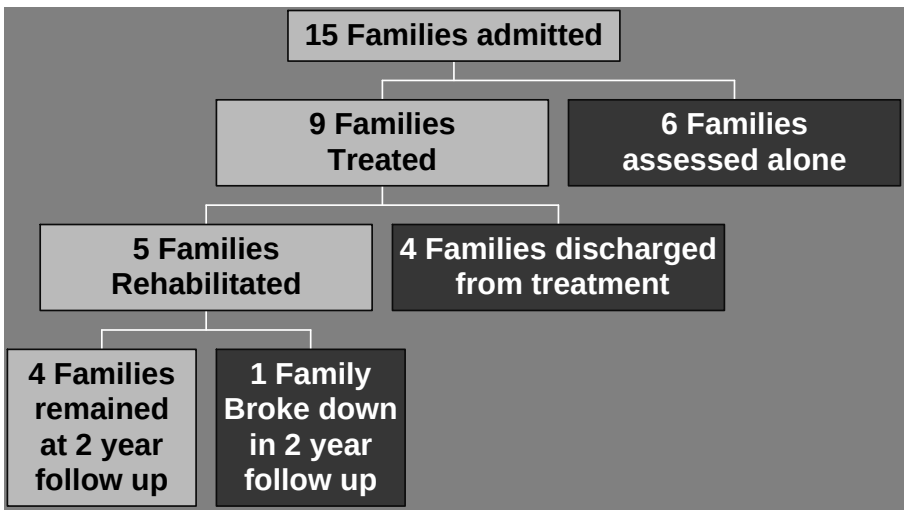
[2] Behavioural, emotional and offending behaviour here were recalled by the social worker only anecdotally and without reference to case notes as these had been re-allocated after permanency was achieved. As each of these children had been subject to care proceedings, the cost of the making of a care order was also incorporated into the cost of each child. The number of changes to placements for these children before achieving permanency was not recorded due to lack of available data.

to commissioning bodies. The idea of total cost is better obtained by the t-test than the Mann-Whitney test, as this considers the mean cost as opposed to the median cost. Thus, whilst neither test is ideal, an argument could be made for the use of either test. As we were concerning ourselves with the total projected costs incurred by the local authority for children where a psychosocial intervention was entertained, compared to that group of children where such an intervention was not entertained, we therefore used the two-sample t-test to gain an understanding of the cost–benefit difference between groups.

The significance of the results can be determined by the size of the p-value that results from the analysis. A p-value of less than 0.05 is regarded as evidence of a statistically significant result (at the 95% confidence level).

Results

Figure 2: Clinical Outcomes: Families fate at two years follow-up

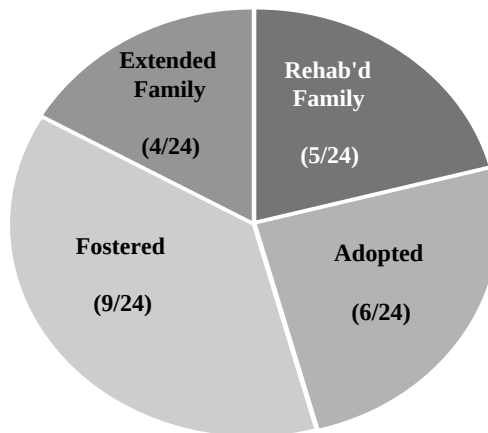


Of families admitted, six were assessed alone (40%), with children then entering a placement other than with the immediate family. Of the remaining nine families that went on to receive a treatment (60%), four (44.4%) of these were rehabilitated at two years follow-up. Four of 15 families (27%) admitted thus existed as rehabilitated families at two years.

With regard to the 'rehabilitated' subgroup identified at follow-up, two families had existed as a family prior to admission, i.e. with children not having entered foster placements and two families had been living separately prior to admission. With respect to the family that had been rehabilitated but broke down in the follow-up period, all children had lived in foster care placements of moderate costs before admission and had returned to such a provision after breakdown of the family.

In relation to the subgroup of families not 'rehabilitated, nine out of the ten had not been living as a family before admission. In the family for which this was not true, the child had been admitted at birth and the family discharged within the treatment period three months later.

Figure 3: Clinical Outcomes
Children: Placements of Children at two year follow-up (n=24)



Eight children (33%) were returned to a rehabilitated family on discharge. Five children remained with a rehabilitated family at follow-up. The local authority identified no additional support needs in these children, with no emotional, behavioural or offending difficulties identified. One child was of school age and attending mainstream school, with no requirement for a Statement of Education Needs identified.

Three children from one family returned to foster care. Two of these children moved to a subsequent foster care placement together before permanency was achieved, thus receiving two changes to their placement since discharge. Both children had behavioural difficulties and had received Statements of Educational Needs. One attended a Special Unit within a mainstream school, whilst the other attended an EBD school. The final child of the three to be placed had remained with the initial foster care placement, thus receiving one change and requiring no additional support. The child was not of school age and no concerns had been identified in relation to emotional, behavioural or offending difficulties.

Of those 16 children (66%) not returning to their families, half received one change to their placement and half received no change until permanency was achieved. No additional support needs, no emotional, behavioural or offending behaviour were noted in any child in any of these placements. Eight children were of school age, of which all attended mainstream school with no

requirement for a Statement of Education Needs identified. No child admitted returned to a high cost placement.

In all cases (100%), permanency was achieved by follow-up. Twenty-three children (96%) had received one or no changes to their placement before permanency.

Thus, five out of 24 children (21%) remained with their rehabilitated family at two years. Of the remaining 19 children (79%), 17 (89%) exhibited no additional support needs and no emotional, behavioural or offending difficulties.

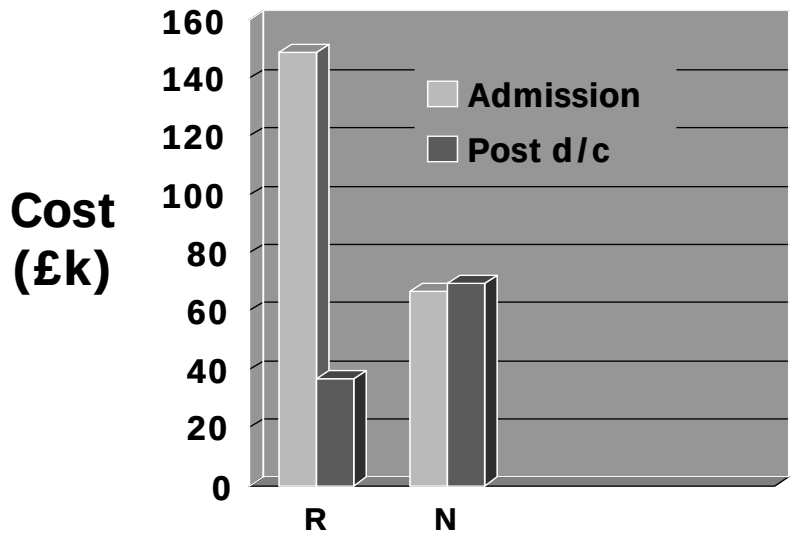
Table 1: Costs include those incurred by family to social services and exclude any costs of parents to services: Family Costs to point of intervention

Family	Intervention A = assess AT = assess + treat ATR = rehab	Children not admitted	Children admitted	Total Presenting Family Cost (£n)	*Contributing cost (£c) of previous children in proceedings, not admitted. ( ) = c/n
1	ATR	1	1	25,000	----------
2	ATR	5	1	399,448	366,694 (0.92)
3	ATR	1	1	174,697	100,826 (0.58)
4	ATR	0	2	50,000	----------
5	ATR	0	3	120,993	----------
6	AT	5	1	134,324	100,866 (0.75)
7	AT	0	1	62,931	----------
8	AT	4	1	171,612	146,612 (0.85)
9	AT	0	3	100,421	----------
10	A	0	2	50,000	----------
11	A	5	1	313,464	254,631 (0.81)
12	A	0	1	36,2778	----------
13	A	0	1	61,653	----------
14	A	0	2	199,431	----------
15	A	1	3	43,269	----------
Total		22	24	**1,943,519**	**969,629**

From Table 1

The average total cost of all families admitted to the Cassel Hospital at point of intervention was £129,568 (range from £0 to £399,488). In families with previous children subject to care proceedings, the average cost by time of presentation was higher, at £193,926 (range £100,826 to £366,694). Within these families, the average contribution of children in previous care proceedings, not admitted, to presenting costs of the family was 68%.

Figure 4: Cost of family admission and cost following discharge
(R = Rehabilitated; N = not rehabilitated)



In admitted families, the average duration of an intervention was 22.7 weeks, being longer in those families rehabilitated (41.8 weeks) compared to those not rehabilitated (13.2 weeks).

The average cost of an admission was £107,996. This included the cost of an intervention by the Cassel and the maintenance of any foster care placement for the child for the duration of the admission. Rehabilitated families cost more, at an average of £148,767, compared to those not rehabilitated at £66,616.

The average cost post-discharge for a family to the two year follow up point was £58,376. Families rehabilitated on average cost less in this period at £36,477. Those families not rehabilitated cost an average of £69,326.

Projected cost comparison

The average cost of a child to the local authority, from the point of initial contact to the point of follow-up, was calculated according the pre-admission cost, admission costs and post-discharge costs for a family. This latter cost was calculated with reference to Unit Costs and knowing the length of time remaining in placement once permanency had been achieved. Where a child existed as the sole child in the family, this figure was taken to reflect the cost of that child in the family. Where more than one child existed, the cost was divided amongst the number of children.

Statistical outcome

The analysis performed used the two-sample t-test and a summary of the results is given in Table 2. The figures reported are the mean and standard deviation cost in each group, together with the p-value from the statistical test.

Table 2: Summary of results

Group	**Mean (Standard Deviation)**	P-value
Not Admitted	190,821 (216,210)	0.09
Admitted	294,196 (185,962)	

The projected estimates of cost per child to the local authority were higher in the admitted group of children, with a mean of £294,196 compared to a mean of £191,821 in the non-admitted group. However, the results indicated that there was no evidence of a statistically significant difference in costs between groups (p=0.09) at the 95% probability level.

Following on, the average projected cost to local authority of a child admitted, following initial contact with the local authority, up to their 18th birthday was £294,196. In addition, of the children for whom admission was granted, the calculated average total duration in care placements, with ensuing cost to the local authority, was 583 weeks per child (11.2 years). For children granted a Cassel psychosocial intervention, therefore, the average cost per child per year of contact with the local authority was £26,268.

The average cost to local authority of a child from contact with local authority and not admitted, up to their 18th birthday, was £190,821. The average total duration in care placements for each of these children, from the point of contact with the local authority and with concurrent cost to the local authority, was 497 weeks (9.6 years). Thus, for children not admitted, the average cost per child per year of contact with the local authority was £19,877, a difference of £6, 391.

Discussion

The clinical picture

The principal aim of a Cassel intervention is to ensure that the child is catered for in an environment that will best ensure his welfare and promote his future development, in keeping with the primacy of import given to the 'welfare principle' of the Children Act.

One important facet of this work is to ascertain whether this future should be in the context of the family or outside that environment. From this sample, 40% of families received an assessment alone, with the child being placed

outside the immediate family. All 16 children within this group had achieved, at follow-up, a permanent placement as a consequence to the clinical decision to place each child in care. Those children of school age were attending mainstream school and no additional support needs identified, without apparent deleterious sequelae to the decision to remove evidence. However,

> There are no shortcuts to relationship building when children have been neglected or abused. The processes that enable the development of a loving and secure home with carers that the child grows to know and trust and where the child feels that they belong is still the best intervention for most children. (BAAF 2006)

In recognition of this, families may progress to a 'treatment' phase, to afford a chance of secure attachment. The fact that this is deemed a treatment is merely a nuance of the law, as clinically we remain keen to assess whether the secure home can be with the family or not, alongside providing the psychosocial intervention. The ethos here, then, is that the child needs to know that everything has been done that can be done to afford a chance of family life, in essence that they are wanted, if they are to go on to form a secure attachment in any setting. A balance exists in this phase, wherein a chance for family life must be entertained alongside any detrimental effects to the child as a result of the care that they continue to experience by their parent. Of the 60% of families progressing through this phase, the 'balance' was deemed too negative to continue in 55.6% of cases and family life thus ended. At follow-up, all children of school age were in mainstream school, with no additional support needs identified and no ongoing deleterious effects in relation to the decision to remove being in evidence in their new home.

All children considered thus far had achieved permanency by two years, being reported as settled in their new placement and with no additional needs in evidence. It is often cited in Family Court Proceedings that there may be negative effects to the child's development as a consequence of a delay in decisions around their future care, if they do not then go on to be placed within the family as a result of an intervention. From our sample, however, it would appear that the clinical decisions made in that 'delay' indeed helped promote development in the best interests of the child's welfare.

The clinical decision to 'rehabilitate' is made within the context of a multidisciplinary review and based upon the extent to which the families have worked through their difficulties enough to adequately begin to care for their child in the community. In law, there is a frequent attempt to subsume this decision under the decision to treat a family, though they are distinct. Of the families then progressing to a 'rehabilitation' phase, 90% remained as a family at two years. Where the decision to rehabilitate is taken, therefore, there appears a good clinical outcome.

Overall, for families presenting to the Cassel Hospital Families Unit for a psychosocial intervention, 27% existed as families at the follow-up point, with no concerns held by the local authority as to the children's welfare.

The cost of caring

The decisions that every local authority faces in care proceedings around a child's placement are partly informed by how much the family has cost and is likely to cost in the future. This is a result of finite budgets, albeit an unpalatable one.

The average cost of a family to the local authority to the point of presentation to Cassel Hospital was £129,568, higher in those families with previous children removed (£193,926), whilst the average cost of an admission was £107,996. That is, more had been spent on average prior to presentation that would be spent during the admission of a family and highlights one area of potential cost savings as being earlier access to an intervention.

This statement has two caveats. Firstly, the cost of making a care order was designated as a pre-admission cost. This was done as the application for a care order had been made prior to presentation and so could not reasonably be assumed to be part of the cost of admission, even though the process would carry over into that period. Secondly, the average cost to presentation does not account for the cost of the parents to the local authority in their own history, nor does it take any account of the costs borne by health or by the criminal justice system. On balance, the cost to the local authority may therefore be much higher before presentation. It does, regardless, raise for consideration the financial benefits of an early intervention, with the possibility of savings that could significantly offset admission costs by limiting the time for children in care before presentation.

Rehabilitated families cost more during the admission, as their stay in hospital was longer than those not rehabilitated. However, these families cost less, on average, in the follow-up period, with post-discharge costs to the local authority being essentially nothing in four of the five families discharged as rehabilitated. The total post-discharge costs to two years follow-up, of £182,385, were borne solely by one family breaking down and the children entering foster care once again.

One common difficulty encountered in Family Courts is in the context of a local authority view around each child's placement being based upon an annual allocated budget and therefore necessarily short-termist. It is often considered then more expedient and cheaper to decide upon the alternative to a psychosocial intervention for that year, most often a life in care for the child. The oft-cited argument of avoiding delays and therein deleterious consequences to the child welfare, masking this financial worry, has already been dispensed within our discussion thus far. Here we may further consider the projected estimates of costs for children where admission had never been considered and never presenting to the Cassel, compared to those children receiving a Cassel intervention.

The average estimated cost to the local authority of a child where no intervention was considered, was £190,821 until their 18th birthday. No account was taken of the number of changes to placement of these children before permanency was achieved and six of the 22 children had been placed with one

parent at no cost to the local authority, the other parent being the principal subject of their concern. Further, all allocated social workers had stated that these children had been maintained in low-cost care before permanency was achieved, with no additional needs. These considerations may account, in part, for the lower cost of children not admitted. As cases had been re-allocated, only anecdotal accounts of the child's wellbeing were available following permanency, in contrast to the admitted children who remained allocated.

It does seem rather questionable as to whether all these children did truly have no additional needs, or whether it was more the case that their needs had not been yet identified, especially considering that

> The long term outcomes of children in care are also devastating. They are over-represented in a range of vulnerable groups including those not in education, employment, teenage parents, young offenders, drug users and prisoner.
>
> (Department of Education and Skills 2006)

We must acknowledge a limitation, therefore, with regard to the limited amount of clinical data available in this group. However, with regard to the actual estimated cost to the local authority, this appears less limiting, given these children had indeed been considered in this manner, quite apart from question of the clinical reality.

This comment also holds true for the group of children admitted, who were all deemed 'low cost with no additional support needs' as a function of the absence of emotional or behavioural disturbance or offending behaviour prior to presentation. One explanation is that some children were admitted at birth and so there existed only a potential for such disturbance at admission. In other cases, the local authority responded to concerns as they arose in the family, so that there was insufficient time for the emotional consequences to be laid bare before admission. Lastly, some children that were deemed as having no difficulty likely awaited a specialist assessment for the true extent of their disturbance to be realised, so that the view held by the local authority was disparate to the true extent of the difficulties. These issues notwithstanding, the estimate of the costs appears valid given that they did reflect the level of local authority concern and support.

For every child presenting to the local authority and with admission to the Cassel, until their 18th year, the average cost to the local authority was £294,196. The difference in costs between the groups was not of statistical significance. How does this translate to the clinical reality, as faced by a local authority in deciding upon expenditures in care proceedings? The children afforded a psychosocial intervention would cost on average £26,268 per year of contact with the local authority, or an additional £6,391 per year compared to those children not afforded this chance. Beyond this finding, if we now address the costs from the position of a funding authority in Family Court Proceedings, considering an individual child's future, we may impart a guiding understanding of the likely average costs, from this group of children having received a Cassel intervention.

Overall, then, for a child admitted to the Cassel and (based on the information of the child's placement at two years follow-up) an estimated projected extra expenditure of £103,375 per child up from the point of local authority intervention, through the period of admission until their 18th year, 21% of children remained with their family.

At the two year follow-up point, no concerns were held as to their welfare, nor any additional support needs identified by the funding authority. Of those not returning home, there appeared no emotional or behavioural sequelae as a consequence to the delay in decisions around permanency in 89%. Taking a group perspective, this equated to an estimated, projected extra expenditure of £6,391 per child per year through their childhood contact with the local authority, for each of those children receiving an intervention at the Cassel Hospital. Each admitted child spent an average of 1.6 years more in contact with the local authority compared to those children in the group not admitted. This figure reflects the balance between earlier presentations to an authority (and hence the potential for a greater total duration in and cost of care proceedings) and the potential cost saving within the rehabilitated subgroup through reduction of the duration in care proceedings, that is the 21% of children who went on to be discharged from local authority care.

Whilst this study examined the costs of children to the local authority in childhood, any reduction in costs to the local authority from a generational standpoint, by breaking the cycle of abuse and repetition and thus reducing the cost to the local authority, criminal justice and health systems are not taken into account in this cost estimate. Additional long-term follow-up studies will be needed to elucidate these aspects. Neither is there any account taken of costs of the parents to the local authority prior to an intervention, nor indeed any reduction in costs from any resulting clinical benefit in parents, both of which may be significant. A prior cost analysis of one family had estimated the sum to be £2,867,495 to the point of admission for that family (McQueen 2008). This included the costs of the parent to the local authority, of the child up to the point of admission, as well as the cost of removing previous children to care for the duration of their childhood. The costs to health and the criminal justice system were not included in this figure, neither were any subsequent costs borne beyond the point of admission for those receiving an intervention included. Whilst the clinical outcome was not accounted for in this figure either, it does, nonetheless, serve to highlight just how expensive a family may become without an effective intervention.

Additional costs of breakdown of placements outside the period of follow-up are similarly not accounted for in our current study. Alongside, projected estimates of costs are based upon the placements of each child at follow-up, where permanency had been achieved. Whilst it is hoped that the lack of concerns reflect the capacity for stable attachments as fostered by the psychosocial intervention, this does nonetheless introduce the obvious possibility that the clinical picture may change within that period as to affect the costs of the child to the local authority. There does remain, therefore, the need for longer

follow-up data on children discharged and this represents a significant area for future research.

There are, of course, various other limitations to this study. The sample size is small, raising the question of applicability to the wider population. There is, however, a general consensus of the legal process that these families presenting are among the most disturbed of the population, so the notion that such work may be applied to a less disturbed population does seem plausible. The follow-up period of two years may be too short to realise any detrimental effects from the intervention, though one would assume that any disturbance would be noted in either the arena of school or home life, which it was not. Cost estimates are based on average unit costs and so the question of precision of costing arises. In the absence of any more accurate data, however, these remain a useful guide. In the comparison sample of children not receiving a Cassel intervention, there existed a relative lack of clinically verifiable data, with anecdotal accounts alone available. Yet we can say that in 100% of these cases, family life did not continue. The comparison group was also gained from a different time period, before referral of families to the Cassel service, so that by the time families actually presented any clinical improvement in the care of children may simply have been a function of the parent's capacity to learn within the period that had passed up to the point of referral. We cannot therefore say with absolute certainty that the psychosocial intervention was central to any improvement. If the intervention is solely identifying those families where learning has happened and is possible, to the benefit of a child, then surely this is still a valuable intervention nonetheless.

Conclusions

Childcare case law states that 'It is impossible to assess a young child divorced from his environment. The interaction between the child and his parents … is an essential element in making any assessment of the child' (Re C (A Minor) 1997) in recognition of the fact that a parent forms an important aspect of the child's environment and hence his developing relationship with the world. With this background context, the subsequent ruling that 'There is no … right to be made a better parent at the public expense' (Lord Scott 2005) equates to the sentiment that there is no right for a child's environment to be made better at the public expense. Further, this statement was made without a true understanding of what the actual expense might be, regardless of the moral sacrifice one must make to embrace such a policy.

This retrospective study begins to bring a true understanding of the clinical and financial cost and benefits into focus, with reference to a group of families afforded an intervention before the ruling to dislocate the funding of assessment from treatment because of 'public expense'. Moreover, we can now describe an estimate of this 'public expense' and the clinical benefits afforded to children as a result.

Based upon the situation at two years follow-up and for an extra projected expenditure of £103,375 across childhood (less than the cost borne before

presentation), or an extra £6,391 per child per year of contact with the local authority, every child in the sample was granted a 21% chance of family life; 44.4% of treated families remained rehabilitated and together at two years. Those children that did not return to family life all achieved permanency within two years of follow-up, with the experience of one change or no change to their placement in 89% of cases. The issue, often raised in court, of a disruption to the child's capacity to form healthy attachments as a result of any delays in decisions around their future care, did not seem apparent in this outcome.

This difference in costs to the local authority between children admitted and those not admitted was not statistically significant. Does it remain ethically viable to deny a child and their family the chance of a life together for an estimated extra cost of £6,391 per year per child to a local authority? Given the somewhat lacking 'public expense' alluded to in Lord Scott's ruling, does this finding now entitle the parent to be made better in recognition of this misguided understanding, or grant the child the opportunity of being better parented?

Perhaps the answer to the important question of funding such struggling families lies more with the issue of where any costs should be borne. Undoubtedly, children who are settled in care and maintained in low cost placements without additional needs would represent savings to health and the criminal justice system compared to those whose needs had never been addressed with an intervention, a statement borne out by existing outcome data on such children as already discussed. There exists here a potential for central funding of such vulnerable children and families with an allocated, central Government budget that is beyond the limited purse strings of a local authority. This potential awaits a realisation, with the knowledge that:

> The test of the morality of a society is what it does for its children.
> (Dietrich Bonhoeffer, anti-Nazi activist 1941)

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Therapeutic Community Principles and Inpatient Care in the Greek Army Psychiatric Service

Dimitrios Moschonas and Theoni-Fani Triantafillou

ABSTRACT: The purpose of this paper is to present the Democratic Therapeutic Community (DTC) and Group Analytic (GA) principles in respect of the acute inpatient psychiatric care and therapy modifications applied in the locked psychiatric clinic of the 414 Military Hospital.

Three methods were used: (i) modified questionnaires recording the clinical experience of the staff; (ii) clinical records on groups' supervision, i.e. session notes and statistics (data derived from the archives of the 414 Psychiatric Hospital); (iii) therapeutic community, milieu therapy, group psychotherapy, inpatient treatment, group analysis, internal care, institutionalised psychiatric treatment (MEDLINE 1995–2006).

The basic theoretic concepts and principles of the Democratic Therapeutic Community were analysed and related to their three-year application in the frame of locked inpatient psychiatric care, considering the constraints and the particularities of the present military environment.

The structure, the function, the stages and the clinical experience that have derived from the application of modified principles of a TC Model in the present military inpatient clinical context are described in comparison to the traditional Hierarchic Biomedical Model; in addition, the impact of the modified principles on the classic roles of clinical personnel involved in the therapeutic role, as well as the development of a constructive working environment among the staff and the inpatients is discussed.

A climate of constructive inquiry was encouraged by flattening the hierarchical pyramid. Both patient and personnel were encouraged to relate their novel views and experiences in the daily

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psychotherapeutic/sociotherapeutic group activities, contributing to the amelioration of diagnostic and therapeutic work, along with the change of attitudes about mental illness as far as the patients and the staff are concerned. Security aspects were fostered and risk problems inhibited, while relapse, re-institutionalisation, and duration of inpatient stay were decreased. Therapy compliance and active involvement of personnel in services were ameliorated, and personal responsibility and sense of satisfaction were promoted. Consequently, clinical services were upgraded and therapeutic rehabilitation was reinforced.

The importance of sociotherapy as complementary and equivalent to psychotherapy is also analysed. The application of sociotherapeutic groups, the importance of games, and the creativity in therapeutic practice, to severely-diagnosed disorders are particularly discussed. The transformation of the clinical staff (i.e. psychiatrists, nurses, psychologists) into active therapists and the constructive collaboration among them has been evaluated.

It was concluded that the application of TC and GA principles in acute inpatient psychiatric care could originate constructive therapeutic approaches, which are humanistic in nature, and gratify both the staff and the hospitalised individuals.

The suggested model could constitute a prototype of alternative functioning of therapeutic principles in a military context, as well as in a broad psychiatric environment in Greece, where acute inpatient psychiatric care bears trends of institutionalisation compromising the roles of both the patient and the therapist.

Introduction

Even though it might seem odd to put into practice principles of Democratic Therapeutic Community and Group Analysis in a Military Psychiatric Clinic and to combine them with the principles of Military Psychiatry, these three therapeutic methods share both their origin and history. They were first combined and developed during World War II in Great Britain (the so-called 'Northfield Experiment') (Main 1946; Jones 1968).

Therapeutic Communities humanised the Asylum to a great extent but failed to dispense with the negative outlook on mental clinics (Gofman 1961; Asch 1986; Barton 1976).

Major theoretical influences

The most important notions and ideas that have influenced and formed the Therapeutic Community theory have been derived from:

Psychoanalysis (the creation of a free space within a structured boundary, Defence Mechanisms, Transference – Counter-transference).

Theories on Group Function (Bion – basic assumption functioning, Foulkes – the group Matrix, assuming the conductor's role rather than the group's leader role).

Studies by Organizations and Social Care Systems (traditional asylum structures have a negative effect on inpatients both on a social, as well as on a psychological level, since staff behaviour and expectations have a profound impact on the way patients perform).

Stanton and Schwartz (the subconscious group dynamics of staff may greatly influence patients, both individually and in terms of the overall therapeutic structure).

Menzies' theory on defences against stress.

Main (staff dynamics that concern patients are considered as 'special' and certain patients may divide the staff. The solution lies in Staff Group Discussion – the Sensitivity Group).

The Systemic Theory (the individual is considered as a part of the system. Dysfunctions can be tracked not only on the individual but on the relationship nexus of which he is a part).

Foulkes' view (someone is 'neurotic' just because he has been cut off from his social frame).

Although the TC was developed in the military context, only a few therapeutic experiments have been applied in the military mental health service of other countries throughout the world. Lange and Bradley (2001) focus on the multidimensional use of community meetings in the military environment and also mention some older attempts to apply TC principles in a military context in England (Harrison 2000), the USA (Wilmer 1958; Briggs 2000, 2001), Israel (Neumann & Levy 1984) and even in Greece (Giouzepas 1981; Tsegos 1996; Kokkinidis 1988).

Now that the focus has turned to treatment within the community, inpatient therapy has been downgraded and patients often consider it to be unsafe and anti-therapeutic (Mind 2000; DoH 2002:8; Norton 2004; Firth 2004). Especially for the Greek Army, where inpatient treatment is obligatory, staff members are always faced with the dilemma of incorporating mental disorders safely while at the same time providing a humane and therapeutic environment (Campling & Haigh 1999; Haigh 2000).

From its early days the TC has evolved into a radical movement and has nowadays come to be viewed as a scientifically-established and efficacious method (Kennard 1983, 1998).

The TC principles are applied in various therapeutic and judicial structures, in inpatient or outpatient treatment centres, as well as in day hospitals, mostly in Anglo-Saxon or other European countries.

Therapeutic community, group analysis and military psychiatry: the biopsychosocial model in the psychiatric clinic of 414 MHSM

The Therapeutic Community, Group Analysis and Military Psychiatry standards (Jones 1968) have significantly altered the environment of 'acute psychiatric wards' of the 21st century as opposed to that of the 1960s or 1970s.

Unfortunately, inpatient therapy in Greece remains the same with a partial improvement (electroconvulsive therapy is rare, inpatient therapy isn't the only solution for a crisis, and drugs are given in smaller doses), but psychological therapies, especially TC, are still considered to be a second-class treatment and there is no such approach in most inpatient units all over Greece. Consequently, our clinic has been the first to develop a TC in an acute inpatient locked ward, after the 'Kokkinidis experiment' in an open clinic.

The mental health service users' experiences are far-reaching (Quirk & Lelliot 2004) since, despite the advancements in community psychiatry, hospitalisation still absorbs a considerable amount of the mental health funds and even more users will at some point be hospitalised. At the same time, even the shortest stay in a clinic may have a dramatic effect on a person's identity or his social status – the 'psychiatric patient' label still attaches stigma. Consequently, the users' views on treatment and mental healthcare tend to influence more and more state decisions and are taken into consideration by the national healthcare services (Rose 2001).

The message for open communication and respect for the patients' rights, the need for a treatment according to the mental health services users' feedback, and the established efficiency of psychological-psychotherapeutic treatments have played an important role in changing the outlook and prejudiced or stigmatising stance on mental disorders (Ilkiw-Lavalle & Grenyer 2003; Lieberman et al. 1993; Lieberman et al. 1998).

Unfortunately, in Greece, such an approach is still rare and discussions on it are done piecemeal. Whichever psychosocial interventions do take place are at best considered supplementary to biological treatments and to the dominant biomedical model, despite the fact that everyone accepts, at least in theory, the biopsychosocial model as far as mental disorders are concerned.

The first and most significant reason for applying this particular therapeutic method, though adjusted to the specific conditions of a military psychiatric hospital, was relevant to a shift of focus on behalf of the Psychiatric Clinic in 414 MHSM (Military Hospital of Special Maladies) towards better and more creative working conditions for the staff, in a field that is marked by high stress levels and many therapeutic but also 'destructive' dynamics (Norton 2004; Pilgrim & Rogers 1999).

The model that is being applied over a three-year period attempts to combine basic principles of Military Psychiatry and Community Psychiatry with those of the Democratic Therapeutic Community model and Group Analysis by

actively involving all those who are in the clinic, be they patients, nursing and medical staff, psychologists or trainees.

The cases are treated according to standard Military Psychiatry principles:

Immediacy	Immediate recognition and treatment of psychological or psychiatric problems.
Expectancy	Expecting speedy recovery and return to the unit, with a maximum of 10–15 days of hospitalisation.
Simplicity	Therapy which resolves the patient's problems by simple means (short-term therapy).
Proximity	Treating the cases while in communication with the unit and family.
Centrality	Disorders need to be dealt with in a central location, as close as possible to the patient's unit.
Brevity	Intervention in as little time as possible.

In addition, the principles of the Group Analytic Therapeutic Community model (Tsegos 2002) have been applied in the clinic team along with the fundamental principles of Therapeutic Community (Kennard 1983), and with the Group Analysis principles as applied in the Group Analytic Therapy Model (Foulkes 1964): that is, Democratisation, Permissiveness, Reality Confrontation, Communalism.

Familiar practices, when applying the Group Analytic Therapeutic Community principles in the life of the clinic, consisted of:

- the ability to interchange horizontal and vertical relationships in order to widen the hierarchy pyramid;
- the distribution of responsibilities as well as common decision making;
- open communication;
- chances for active learning and promotion of judging skills as well as chances to broaden personal relationships and roles;
- bringing the healthy part of Ego into action through the transition from the regressed level to the peer's or the adult's level of functioning;
- equality in rights and obligations; and, finally,
- establishing a 'culture of enquiry' based on active experience and mutual learning (therapists and patients learn from one another through their interaction).

Therapeutic processes

The Therapeutic Processes through which these take place in a Therapeutic Community (Haigh 1999) are related to:

Attachment (primary bonds, loss as growth potential) *Sense of belonging*.

Containment (maternal and paternal care) *Safety within the group, support, rules and boundaries*.
Communication (play, discussion) *Free and open communication*.
Agency (to consider oneself as the centre of action) *Strengthening democratic practices and decisions, horizontal relationships*.
I**nvolvement** (to find one's place among others) *Community meetings, Large Group, defined schedule and structure, confronting reality*.

On the basis of these processes we have attempted to promote the feeling of 'belonging', of security and alliance (e.g. 'Spirit of the Unit' in the army), by re-inforcing communication and democratic practices as well as basic equality, in order to involve each member in the clinic interactions and avoid seclusion.

The description of hospital and clinic

The 414 Military Hospital for Special Maladies is an old hospital built in the 1950s. Until the 1990s it operated as a hospital for tuberculosis and other pneumonic diseases because of its position in the Penteli Mountains of Athens. The psychiatric clinic was transferred to this hospital in 1993 from the 401 General Military Hospital of Athens (the largest central hospital of the Greek Army) against the scientific will of military psychiatrists who perceived this transfer as exclusion in the 'tuberculosis asylum'.

The director of the hospital is the most senior serving officer physician, regardless of specialty. Apart from the psychiatric and pneumonic disease clinics, the hospital also has a department responsible for the control of army hygiene, as well as a department for the annual check-ups of military personnel. This latter department is also responsible for the clinical control of candidates for military academies and the professional military staff. In 2002, the Department of Natural Medicine and Rehabilitation was established. The clinics are directed by specialist career officer physicians; they are staffed by conscript doctors undergoing specialist training or civilian residents undergoing their specialisation in psychiatry, as well as conscript psychologists and social workers. The senior nursing staff are career officer nurses, while the junior staff comprise professional soldier nurses; remaining administrative technical staff are officers, non-commission officers, soldiers of the Greek Army and civilian employees.

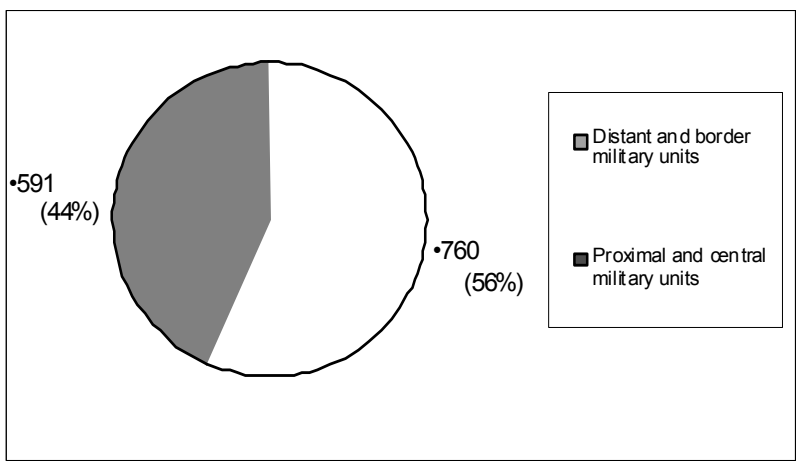
The 414 MH Psychiatric Clinic is a short-stay inpatient unit for acute cases (to a large extent), with a 30-bed capacity, and is the only locked central clinic of the Greek Army. It admits cases from a wide psychopathological spectrum: acute or serious cases of psychotic episodes and affective disorders, suicide attempts, drug abuse disorders, behaviour disorders, personality disorders, anxiety disorders or even adjustment disorders throughout the course of national service. The total number of patients is 500–550 people per annum.

Table 1: Percentage of clinic's patients' diagnosis (DSM-IV) during the three-year period

Psychotic disorders	17%
Mood disorders (Bipolar, Schizoaffective)	3%
Anxiety, Panic, Obsessions, Somatoform Disorders	17%
Depressive Disorders, Suicide attempts	29%
Adjustment Disorders	1%
Personality Disorders	4%
Drug Abuse	4%
Behaviour Disorders, Mental Retardation, Other Disorders	25%

As far as their military status is concerned, the clinic's patients are career and conscript non-commissioned officers and men. Most of them serve in a vast area of Greece, including the Aegean islands and other units of the interior. In addition, severe cases are taken from the Navy, the Police, Fire Brigade, and civilian employees who work in the army, and some psychiatric cases from the Avlona Military Prison.

Figure 1: Military Units of Patients



The clinic staff consist of six psychiatrists, 2–4 psychiatry trainees, 6–7 specialised military nursing officers, one clinical psychologist and 1–3 psychology trainees. Thus, the psychiatric needs (in terms of prevention and therapy) of a vast sector of Recruit and Training Centers and other military units are covered. There is also an outpatients' department, which operates on weekdays. The clinic's psychiatrists, apart from their duties in the clinic, are also responsible for the hospital's Social Care Section; as a result, they visit the

sections that fall into their care every two months to forestall each section's specific problems and deal with them.

Table 2: Disorders and military status, raw scores

Disorders	Soldiers	Prof. soldiers	Military prof.	Officers
Psychotic Disorders	126	37	22	16
Mood Disorders (Bipolar, Schizoaffective)	18	8	4	7
Anxiety, Panic, Obsessions, Somatoform Disorders	172	43	11	7
Depressive Disorders, Suicide Attempts	224	57	41	68
Adjustment Disorders	13	1	0	0
Personality Disorders	49	2	1	0
Drug Abuse	32	12	2	0
Behaviour Disorders, Mental Retardation, other Disorders	209	58	31	38
N=	843	218	112	136

The clinic operates on a handling and interchanging of cases basis (with an average of 12–15 days of hospitalisation and a 4–40 day stretch, due to the special conditions of military service). Every trimester drafting and selection procedures are performed. The case flow from those already in service is constant and, besides psychiatric supervision, 'estimation of mental health ability' is also conducted on reserve officers or standing personnel that happen to be in therapy. The doctors are also interchangeable in the clinic because of other social care duties they may have in a quite vast part of the Greek State.

This means that the clinic, due to its special conditions, needs to diagnose and assess the cases as quickly as possible, to treat them in the least amount of time possible and to focus on dealing with crises and pave the way for systematic psychotherapy and medication outside of the clinic, the so-called follow-up.

Conditions of operation

Since its foundation, the clinic has applied the traditional medical psychiatric model, in terms of both function and structure. Clinical work was based on observation, diagnosis and treatment (mostly drug therapy) of mental disorders in combination with the necessary 'military somatic health ability judgement' (I3, I4, Deferment, Discharge or Convalescence-leave). Severe cases were detained and had forced drug therapy while the psychosocial perspective consisted only of a traditional ergotherapy.

The patients remained alone all day long and secluded in their beds, waiting for a session with their doctor. The nursing staff were interested in giving drugs, in the surveillance of the patients and especially detecting violent behaviours. There was a lot of fear and isolation for the staff and the patients as well. Consequently, there was no room left for therapeutic alliance.

The attitude of the whole military personnel towards the hospital ranged between fear and hostility. For many years it functioned as a threat in matters of discipline! Military Psychiatrists had the feeling of isolation and wanted to get back to the 401 General Military Hospital, and staff coming into the hospital were not at all contented.

The timing for the change was good indeed: the previous director had a psychoanalytic approach; the staff were tired and wanted to change the traditional biomedical style of the clinic; and, finally, there was a discussion on the goals of military psychiatry, and on its relationship to social and community psychiatry. The pioneering work, valuable advice and experience of Dr Kokkinidis were offered as a supervisory guide in this attempt to change attitudes in such a conservative, strict and hierarchical environment. The first step was to sensitise and train the existing staff of the clinic in the direction of creating new therapeutic conditions.

Shaping the psychiatric clinic's therapeutic programme

In mental health buildings seldom does the exterior appearance set the scene for a warm entrance. The Dutch architect Aldo Van Eyke, who deals with mental health institutions, stated: 'Make a countenance of every window and a *Welcome of* every door.' What Van Eyke describes as 'creating a homely environment process' in the almost non-existent bibliography on psychiatric grounds' architecture became the cornerstone to a step-by-step reflection; a reflection of the sensitivity required for therapeutic work. In order to support the therapeutic model on which the clinic's function is based, the whole environment had to be reshaped in such a way that every inch of it would be proof that the *mother* community puts the patient first. The walls were repainted in different colours, patients were allowed to draw on them, suspension ceilings were created and new lighting was installed in tall-roof corridors and rooms. More spacious rooms were formed, some serving a new function, like the isolation chamber that became the gym; an area for group psychotherapy was set aside, which is commonly called the *Welcome* area; and the sanitary and eating areas were renovated, in an attempt to fully transform the clinic. With respect to individuality, and in order to enhance it, the number of patients per room has been reduced.

More attention was paid to an issue that quickly surfaces when it comes to psychiatric clinics: safety. It is important to differentiate between being safe and being constrained or imprisoned. Under the light of our therapeutic approach, the clinic's bars were removed and window frames were replaced by more secure ones. The locked door was selectively opened for certain outdoor group activities: the Coffee Group has many times taken place under the shade of the

yard's huge pine trees and the hospital's kitchen has hosted the cooking group. The exterior environment has served as the clinics' outdoor expansion for therapeutic activities.

Along with this step-by-step change of the environment, the programme for the dyadic or group therapy activities was shaped and it took about a year for it to work in the way we had imagined; during the past three years, after sufficient experimentation and tests, it became functional, flexible and well received. The therapy programme in the 414 MH Psychiatric Clinic is a 'milieu therapy' programme and it incorporates sociotherapy and psychotherapy groups, which are considered to be as effective as a one-hour therapy session.

Table 3: The weekly schedule

Group Name	Membership	Frequency
Large Psychotherapy Group	TC staff/members	1/week
Small Psychotherapy Group	TC staff/members	2/week
Coffee Group	TC staff/members	2/week
Art Therapy Group	TC staff/members	2/week
Various Activities Group	TC staff/members	1/week
Welcoming Group	TC staff/members	Every day
Spontaneous Group Activities	TC staff/members	
Ward round Group	TC staff/members	Everyday
Sensitivity Group	TC staff	1/month
Supervision Group	TC staff	1/month
Nurses' handover Group	TC staff nurses	Everyday

Therapists' and patients' groups

Psychotherapy groups
Large Group (Group Analytic Model) – Community Meeting
Small Group (Group Analytic Model)

Sociotherapy groups
Coffee Group
Art Therapy Group
Various Activities Group

Other groups
Welcoming Group
Spontaneous dyadic or group activities (cooking, arts and crafts, working out, ping-pong etc.)

Group participation is voluntary. The patients are informed by the Welcoming Group about the clinic's schedule, principles and rules. According to the rules of all groups, violence and sexual harassment are not allowed and both patients and therapists are bound by medical secrecy.

Patients from the whole diagnostic spectrum take part in the groups. Representatives of every mental health profession employed in the clinic participate in the sociotherapy and psychotherapy groups (psychiatrists, psychologists, nurses, psychiatry trainees, psychology trainees) and, in order to fulfil every group's purpose, the coordinator's role often changes hands. Usually the group is coordinated by a pair of co-therapists (a professional and a trainee).

Psychiatrists, psychologists and nurses that participate in the groups either already have or are now acquiring experience in coordinating groups. There was a systematical supervision by an experienced group psychoanalyst trainer, on the grounds of the IGAA (Athens Group Analysis Institute) supervision model (Tsegos 2002) and the groups' function was debated and supervised by the Ward Round Group.

Psychotherapy groups

Large Group (Group Analytic Model) – Community Meeting
This is a steady group that operates on the grounds of Group Analysis, with a one-hour duration. It runs weekly every Wednesday and consists of 20–25 members. The day's active staff and almost all patients take part. The Warden and Head Nurse are the coordinators (the clinic's symbolic parental figures). A military community atmosphere is dominant, in a permissive environment, however, which is achieved by the emotional involvement between therapists and patients.

The clinic's Large Group conveys its therapeutic culture, its values and rules, thus encouraging adult behaviour and effective personal relations, trust and communication among group members. It promotes a feeling of 'wholeness' and is the place where community spirit is set and put into practice. It widens and softens the military hierarchy's boundaries, while at the same time maintaining stability and a sense of safety within the clinic's scope. It is considered the most significant group and is suggestive of the atmosphere and interactions inside the clinic. To a great extent it shapes community culture and ensures the clinic's cohesion. The group informs about the clinic's boundaries, rights and therapy goals. In addition, patients get to know one another and the staff, while emphasis is put on the importance of therapeutic interaction among its members. The group processes and discusses the events of the past week (be them positive or negative), and information on how the clinic, the patients and the staff are doing is provided.

Small Group (Group Analytic Model)
This group runs every Tuesday and Thursday for one hour and has a psychiatrist and a psychologist as coordinators. It is based on Group Analytic

principles: personal or group matters that concern the clinical therapeutic interventions are discussed more thoroughly, as for example drug therapy; or the nature of each patient's disorder, the conditions and reasons for their therapy, and anything else that has to do with life in the clinic are considered.

Getting to know patients on a group basis grants invaluable diagnostic information, which combined with private interviews lead to speedier and more precise diagnosis that is based on more spontaneous information and improves the therapeutic alliance and mutual trust between therapist and patient.

Sociotherapy groups

Coffee Group (nursing support)
This runs every Tuesday and Thursday for one hour. With the nursing staff as coordinators, the team makes use of the morning coffee ritual as a chance for the members to get to know each other and communicate, so that they may exchange views or emotions. The coffee ritual strengthens the sense of 'sharing' among group members, paving the way for a sense of cohesion and mutual help and increasing trusting relations between staff and patients: the patient soon becomes familiar with the staff through constant interaction, and mutual trust begins to be established.

Art Therapy Group
This group, which uses Art Therapy techniques, is in session every Monday and Wednesday for one hour. With a psychologist as coordinator, the group uses speech and creative activity as a means of exchanging views and emotions. Discussions are on a more personal level. The archetypal world of art constitutes a safe setting for therapeutic regressions and Catharsis. The sessions give rise to valuable qualitative data in order to deeply understand the point of view of the patient him/herself.

Various Activities Group
This group is in session every Friday for one hour and it constitutes a sociotherapeutic group using fantasy plays, group games, and practical or constructive activities. Personal attitudes and emotions find their way out, on the basis of common activities, while members can share delight and joy. Finally, other forms of group activities include several happenings, such as an arts and crafts bazaar, exhibitions of the patients' artwork, cooking, board game tournaments, parties etc.

Welcoming Group
Some patients, the duty doctor and a nurse welcome every newcomer to the clinic and brief them on the clinic's rules and its activities' schedule. This group aims at greeting each newcomer with a 'warm welcome', at boosting mutual help, and reducing the newcomer's possible stress.

Therapists' groups

Ward Round Group and Sensitivity Group
In the daily ward round, clinical, organisational and personal matters are discussed: matters that greatly help to form a common therapeutic attitude and to resolve any problems that may come up among staff members. These matters are considered of utmost importance, as far as the running of the clinic's community is concerned (Haigh 2000). Information on the activities of the groups' members plays a major part in clarifying the diagnostic impression as soon as possible and provides a deeper understanding of each case and thus better treatment.

In our case, the Sensitivity Group meeting was held occasionally (usually once or twice a month) and was composed of most of the clinic's staff. Issues about life in the clinic, personal relationships or cooperation were under discussion, especially when incidents that affected the clinic's atmosphere, positively or negatively, came about.

Supervision Group
The Supervision (of group activities) Group came in session monthly and included all staff that took part in group activities, therapists and trainees. Supervision was based on the Group Analytic supervision model as defined by the IGAA (Tsegos 2002) with the Supervision Group as supervisor and an experienced group psychoanalyst as observer, in our case the director of the clinic.

We often noticed that the dynamics of the staff's groups (Supervision, Visiting and Sensitivity) were mirrored by community groups and vice versa. We also noticed that the ward round group served as the Sensitivity Group several times as well, or as the Supervision Group, when organisational issues that concerned the clinic's function as a whole came up.

Nurses' Handover Group
Organisational and personal matters are discussed: matters that greatly help to form a common therapeutic attitude and to resolve any problems that may come up among the nursing staff. Valuable information for the patients is analysed, since the nursing staff spend more time near and with the patients in their everyday practice.

The psychiatric clinic and network for psychosocial care

During our three-year course we ascertained that the application of the principles mentioned above is possible and effective in an inpatient military psychiatric clinic and it is obvious that it complements and facilitates the therapeutic process in a field that is by definition rigid, based on hierarchy and frequently of forensics nature. Similar circumstances and clinical experiences may be located in previous successful efforts to apply the community model to a military environment in Great Britain (Harrison 2000), in the USA (Wilmer

1958; Briggs 2000, 2001; Lange & Bradley 2001) and Israel (Neumann & Levy 1984), as well as in Greece (Giouzepas 1981; Kokkinindis 1988; Greek Navy).

In our case we managed to interchange even more roles: psychiatrist or psychologist or nurse as psychotherapist (individual or group), military personnel etc. We thus managed to form a nexus of horizontal and vertical relationships and role interchange that facilitate therapy on a personal level, as well as on the whole therapeutic structure. Staff have a duty not to completely 'cure' the patients, but to be able to work in such a way that will enable patients to continue with their therapy either from their homes, in other outpatient structures, or to be able to carry on with their military service under supervision if needed.

A network of psychosocial care extending from the clinic to military units, (Papavasiliou & Moschonas 1999), including distant units in rural mainland and border islands, as well as central ones, covering a vast area of the country, was established. This was made possible by using psychiatrists, psychologists and social workers from the clinic, who visit the units and provide on-site psychosocial support and screening, leading to referrals to the clinic or ensuring local follow-up. In addition, a 24/7 support help-line was set up in the clinic to provide psychosocial support and counselling over the phone. The clinic also had the duty of training the teams of psychosocial care. These teams consisted of conscript psychologists, sociologists and social workers, who operated in distant units in a preventive way. These very teams transferred the message of TC principles to their units and kept in contact with the clinic for their supervision.

All these activities offered a framework of Preventive Psychiatry to the units; they reinforced the communication between the unit and the psychiatric department and transformed the negative attitude towards the clinic. We should mention here that our patients going back to their units constituted the best 'advertisement' of our work and also have proved to offer valuable help on matters of preventive medicine.

Under these conditions, it was not difficult to establish community and group culture and to combine them with the principles mentioned above so that everyone involved in the therapeutic process could benefit, because the so-called Unit Spirit which ensures its cohesion is already dominant within military environments (Moschonas 2001).

The culture and the key methods of the model

This method attempts to render every interaction within the clinic therapeutic community (Campling & Haigh 1999), and to decrease any destructive forces (Roberts 1980) that always exist in every clinical field (Campling, Davies & Farquharson 2004).

It establishes a 'culture of enquiry' (Lees et al. 2003) as far as therapeutic environment issues are concerned through an active, vivid and corrective learning process. It shapes a new scope on mental health myths and the 'dangerous' patient notion, a notion inscribed on almost every patient that

arrives in a clinic, and activates all available healthy forces, overriding at the same time the almighty therapist myth, from which a patient may passively await to be rehabilitated (Tsegos 2002).

It is important to mention that applying such a model requires extensive knowledge of organisations' group dynamics (Isohanni 1989). There is also need for expertise and experience on systemic, group analytical and psychodynamic, and psychotherapy principles, as well as further education of the staff on them. In this aspect, coordinating and managing such a structure is fundamental if one seeks to maintain and promote community spirit, which could very easily be overbalanced.

The staff's cooperation with experts that have different theoretical or clinical views poses several problems until they are incorporated in the community model. Once that happens, though, they enrich dialogue and significantly help to form a therapy model (Leibenflut, Tasman & Green 1993).

There is no doubt that the inpatient field is tough and unpredictable and, especially in Greece, still fosters rigid and asylum-like notions to a large extent.

Back in 1978 Gunderson described a series of methods that, when applied in the clinic's environment, have positive results. He set five 'key' methods.

- **Containment**. To relate to the patients' sense of security and integrity, within a fixed relationships nexus that contributes to prevention of violence and diminishing of relapse and dangerousness. In this way the patients' self-control is strengthened and they are able to realistically deal with any destructive tendencies they might have.
- **Support**. It refers to every effort that aims to enhance a patient's self-respect.
- **Structure**. The environment's structure means to promote a change in the patients' symptomatology or any socially maladaptive behaviour they may have.
- **Involvement**. It refers to the methods that drive the patient to get involved in the clinic's schedule or environment.
- **Validation**. Respect, toning of individuality and the patients' rights by providing opportunities to try new things and activities. At the same time, acceptance of their symptoms and relapse are considered as a natural occurrence along the lines of their therapy.

We believe that the therapy model formed by the 414 Military Hospital Psychiatric Clinic meets all five of the above methods and may pose as a basic model: an alternative perception of acute cases inpatient treatment in our country, where the 'milieu therapy' term means merely a few hours of ergotherapy.

The model's particularity: observations and conclusions on the effect of psychotherapeutic interventions

The 'milieu therapy' model and the psychosocial interventions in our Psychiatric Clinic are particular in the sense that, although they are applied on a short-term hospitalisation basis, they manage to establish a 'democratic' community and group culture among patients and staff, through a complete programme of everyday group activities which boost group cohesion and mutual help.

During its three-year course, several clinical observations, effects and conclusions have come to light, which we believe have ameliorated the clinic's performance and its therapeutic work.

The observations on the way groups and community spirit worked in the clinic can be summed up as follows.

a) Hospitalisation conditions and the clinic's structure

The clinic operates as an environment for the management of an acute case, preparing the patient for therapy and rehabilitation (psychotherapy, drug therapy, or a combination) on an outpatient basis, open mental health (through appropriate referral), or in systematic care and follow-up in cooperation with the psychosocial support network.

- Prevention of return of patients into inpatient care.
- Significant reduction in violent incidents (self-harm or harm to others) and increase in the feeling of safety among the staff, the inpatients and their families.
- Therapy aims to reassigning the role of the patient as well as of the disorder itself.
- The combination of vertical/dyadic communication – interview and horizontal communication within the frame of groups, increases the diagnostic ability and the understanding of every case while focusing on its individual properties. At the same time it produces results in a relatively short amount of time.
- Shortening of hospital stay and better management with faster recovery of acute cases (psychotic and emotional).

b) Patients and their families

- Better compliance with drugs and less indications for high dose medication.
- Greater participation of the inpatients and their families in the process of therapy and greater trust towards the staff.
- Spirit of mutual support between the inpatients (the old ones introduce recent ones to the activities of the clinic).
- Effectiveness of the exchange of roles since there is chance to move from the role of child to same age-adult, support from the colleague who is usually more therapeutic that the support from the expert.

- Fast and effective development of the therapeutic alliance between patients and the staff, lessening in the feeling of isolation, dismissal of fixations about the psychiatric illness and the mental health services. More regular contacts and therapeutic communication with all kinds of mental health experts and for longer times.
- Better compliance for a multifunctional psychodynamic therapy.
- Better therapeutic outcome, better recoverability, and reduction of mental health casualties.

c) Staff members

- The staff gain more satisfaction from their work. More personal relationships between members of the staff, development of initiatives on the basis of personal interest. Possible conflicts can be normalised and contained more easily. Avoidance of staff burn-out.
- Smooth transition from distant professional roles (of psychiatrist, psychologist, psychiatric nurse), to active therapists and members of the community of the clinic. Better collaboration between psychiatrists of different psychiatric approaches and mutual learning.
- Widening of the scientific and military hierarchical pyramid in the framework of the staff, resulting in stable but flexible relationships between colleagues and increased consistency in the team of professionals.
- The staff orientates, empathises and learns in the psychodynamic model of therapy on the principles of the Therapeutic Community and Group Therapy.
- Change in the view about the myth of the dangerous, high-risk psychiatric patient and the symbolic almighty power of the therapist, with more active participation and mobilisation of the nursing staff, as well as other professionals – formation of team and community spirit.
- Better understanding and management of the dynamics of the entire organisation of the hospital in relation to the dynamics of the clinic, resulting in cooperation, activities and events inside and outside the clinic with the participation of other members of the staff and renovation of the clinic's space and environment that remained in bad shape for years.

Assessment of the clinic's environment by the Staff

As far as the staff are concerned, we already have the first draft data on the evaluation of the above on the basis of an organised questionnaire we have constructed.

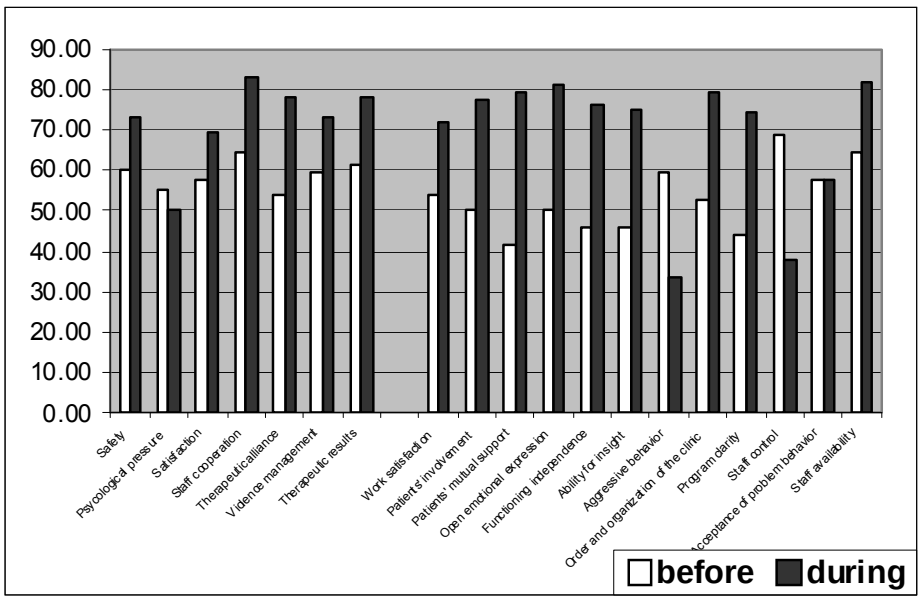
The items of the questionnaire compare the above observations between the staffs' clinical experiences (related to gratification from work, safety issues, therapeutic results, quality of interpersonal relationships between the staff and the patients), before and since the application of this model in our clinic. The questionnaire was filled in anonymously. As one can see, the differences since the application are significant compared to results from the period before that in which the traditional biomedical model was used. The following table (Table

4) illustrates the percentages of the scores on each question based on the raw scores.

This comparative survey is being continued.

Since there was a change in the management of the clinic approximately one year ago, there has been a reversion to a more biomedical approach. However, the sociotherapy groups run by the nursing staff and the psychologists are still in place, maintaining some of the elements of the therapeutic community climate.

Table 4: Assessment of the clinic's environment by the staff, over a three-year monitoring period before and since the application of the principles of the therapeutic community



Probably the best epilogue for this paper would be some phrases of patients while leaving our clinic and waving goodbye. These are some of their prevailing fantasies of the Psychiatric Clinic of 414 Military Hospital.

> Baptizing the soul; a barrier to wildly flowing water; soul SPA; a boat entering the harbor; PC and data; a light showing the end of the tunnel; a starry night.

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The Development of a Fantasy Modification Programme for a Prison-Based Therapeutic Community

Geraldine Akerman

ABSTRACT: This paper describes the development of a fantasy modification programme designed to integrate skills through which to manage inappropriate sexual or violent fantasies within a democratic therapeutic community (DTC) accredited for offenders. Residents participated in the programme and then continued to discuss how they applied the skills learned as part of their on-going therapy. The programme was piloted with four participants at HMP Grendon and this process will be described and critically evaluated in this paper.

Keywords: sexual and violent fantasy modification, therapeutic communities, prison research, Good Lives model, Grendon

The context of the programme

HMP Grendon, a Category B prison, housing 230 adult male prisoners, is the only entire prison that runs entirely as a Therapeutic Community (TC). A TC within a prison provides an environment where a range of behaviours (including those exhibited in the build-up to their offending) can become apparent and therefore open to assessment and change. It provides an opportunity to practise and refine skills learned on other offending behaviour programmes in a meaningful way. HMP Grendon is comprised of five discrete communities. One community is for induction and assessment and four are communities in which men live together and participate in intensive therapy for an average period of 18 months to three years. One of the communities, 'G wing', houses men who have committed offences with a sexual motivation or whose behaviour within prison leads to some concern in this area. The residents are still free to mix with residents from other wings throughout the day, for instance at the gymnasium, chapel, or for education. The regime at HMP Grendon is described by Genders and Player (1995); more recently by Shine and Morris (1999). Further, there is a compilation of some of the research carried out at Grendon, edited by Shine (2000), and by the current author in Akerman (2002). The

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programme was piloted on G wing with men who had volunteered to participate and described having ongoing offence-related sexual or violent fantasies.

The background to the development of the fantasy modification programme

The fantasy modification programme (FMP) was devised as a means of giving residents strategies through which to manage inappropriate violent or sexual fantasies. The lack of specific techniques to manage such fantasies had been highlighted in therapy when residents spoke about the intrusive nature of current offence-related fantasies, and/or sexual preoccupation, but that the programme at Grendon did not teach techniques to manage these. In addition this did not include the level of detail required to provide a step-by-step strategy. So the FMP was devised as a way of teaching the skills to address this need, and thus add to the quality of work at HMP Grendon and be evaluated in the ongoing 'quality of treatment' audit process. The programme was written in line with current research into managing fantasies in a cognitive behavioural manner but the focus remained on integrating it into ongoing therapy within the TC at HMP Grendon, which is accredited by the Correctional Services Accreditation Panel as a means of reducing risk. The development of the programme was discussed and evaluated with the staff and community at all stages and each session was evaluated by those participating and fed back to the community as with all complementary therapies (for example art therapy, and psychodrama).

The programme draws a great deal from techniques used on other offending behaviour programmes, such as the group of Sex Offender Treatment Programmes (SOTPs), and Controlling Anger and Learning to Manage it (CALM). The Healthy Sexual Functioning Programme (HSFP), developed by the Offending Behaviour Programmes Unit to help develop healthy sexuality, was not deemed suitable to meet the needs at Grendon, as much of the content of the programme (for instance in developing intimacy, discussing inappropriate arousal, and getting support to try new strategies) is routinely practised at HMP Grendon so the FMP is tailored in teaching the specific strategies that are not taught at present. In the past, residents were required to have completed SOTP prior to applying to Grendon. This changed with the introduction of the Core and Extended programmes in 2000, but these programmes ceased in 2002. Although these programmes no longer run at Grendon they remain part of the culture, as several members of the staff team have been trained in offending behaviour programmes and many residents have participated in them prior to their transfer and so the terms used in such interventions (for instance schemas, cognitive distortions) are commonplace in the TC. Therefore, whilst the introduction of a more structured programme was novel, every effort was made that it would not be at odds with the ethos of the TC through constant discussion and feedback with staff and residents.

Aim and premise of the programme

The aim of this programme is to help offenders to manage inappropriate sexual or violent fantasies and to develop robust relapse prevention plans in line with the Good Lives model (Ward & Stewart 2003b). The Good Lives model indicates that all people strive for goals, and that these would fall into the following areas or 'goods':

- healthy living;
- knowledge;
- excellence in work and play;
- inner peace;
- intimate relationships;
- spirituality;
- self-management;
- creativity.

The model suggests that offenders could have sought these through ineffective means, i.e. offending, and that there needs to be a treatment plan to account for individual strengths and necessary resources to achieve these goods. The application of the model to fantasy modification was described by Akerman (2005). In line with 'What Works' literature (Andrews & Bonta 1998; McGuire & Priestly 2000), the programme is based on the risk (match between level of risk and amount of treatment needed), need (targets criminogenic needs associated with recidivism that are amenable to change) and responsivity (is comprehendible to participants and tailored to individual needs) principles, and is designed to be applied when a treatment need is identified. Andrews and Bonta also suggest that there should be some clinical professional discretion so that there can be flexibility and innovation. It is considered that behaviour modification techniques, if used correctly, can enable individuals to exercise self-control over, or change, inappropriate interests.

The 'What Works' core principles (McGuire & Priestly 2000) are addressed by the FMP as follows:

PRINCIPLE 1: A programme must be empirical and grounded in theory
The FMP has been compiled with close attention to the empirical literature and theoretical models, including that on fantasy modification, therapeutic community treatment and group process.

PRINCIPLE 2: A programme must target criminogenic needs
The FMP teaches ways to manage deviant sexual and violent arousal.

PRINCIPLE 3: A programme must use methods that are responsive to learning styles
The FMP uses a range of techniques known to be responsive to the learning styles of residents, e.g. group discussion, role-play, cognitive rehearsal etc. in line with therapeutic community principles.

PRINCIPLE 4: A programme must use effective methods
The FMP is primarily cognitive-behavioural in nature, which research (McGuire & Priestly 2000) has found to be effective. It is situated within a therapeutic community, which in itself is an accredited intervention.

PRINCIPLE 5: A programme must teach skills
The FMP aims to teach and encourage the practice of fantasy modification techniques, and planning for relapse prevention.

PRINCIPLE 6*:* A programme must address a range of criminogenic factors
The FMP addresses fantasy modification, developing victim empathy and developing relapse prevention plans.

PRINCIPLE 7: A programme must use the right dosage of treatment
The FMP is tailored to the individual needs of each participant and progress is monitored through ongoing therapy.

PRINCIPLE 8: A programme must make clear reference to throughcare
The FMP work will be integrated into ongoing therapy in line with TC principals and risk assessment included throughout. It will also be reported on in end-of-therapy reports, all of which have a focus on throughcare.

PRINCIPLE 9: A programme must have treatment integrity (i.e. aims are linked to methods; there are adequate resources to run it; there should be training, support and evaluation in place)
Training will be given to each person who runs the programme, and members of a multidisciplinary team will deliver the programme. There is a support structure in place in the work of the TC and the work will be evaluated using appropriate measures. The pilot programme relied on self-report to measure the progress of the participants, whilst the search continues for a more objective measure.

Theoretical basis of the FMP

In order to meet the standards suggested by the 'What Works' literature for effective programme design, a programme must be based on current theory supported by empirical backing. A theory manual should describe the programme's aims, the justification for the aims, identify clinical targets, and illustrate how the programme should be run. Ward, Mann and Gannon (2007) state that when describing programmes it is important that the rehabilitation theory underpins it and that the theory underpinning each session is noted, so as to apply theory directly to practice, reminding and focusing the practitioner, and enabling them to be more flexible in their exploration. Therefore the description of each session includes the underlying theory to encourage the practitioner to be mindful of it.

It is vital that the programme is underpinned by seeking to enhance pro-social goals through the development of a Good Lives plan (Ward & Stewart 2003a) and thus reduce risk. The theories underpinning the FMP are:

- Sexual offending can be viewed as an attempt to achieve 'goods' that all humans strive for, but through inappropriate routes (Ward & Stewart 2003b).
- Many offenders need the opportunity to attain the goals of relating to others, inner peace, and self-efficacy, and to learn the skills through which to do so (Ward & Mann 2004).
- In line with theory that advocates teaching offenders to strive for approach-focused goals, the programme should add to the offenders' skills rather than remove a problem, leaving a 'pinhole' (Ward & Stewart 2003b).
- Therapist style is very important (Marshall et al. 2003; Mann & Shingler 2006, Ackerman & Hilsenroth 2003) and the application of the Good Lives Model – Comprehensive (GLM-C, Ward & Gannon 2006) helps the therapist to reduce the tension they feel by viewing the offender as someone who has committed a serious offence and one who wants to change.
- In line with the GLM-C, the programme aims to work with the participants to identify their current strengths in terms of the model and setting goals to develop less robust areas. The participants should understand the role of fantasy in their life and develop the skills, knowledge and competency to gain their primary goals in an acceptable manner in prison and on release.
- Positive psychology encourages the premise that we should build on strengths: 'amplify client's strengths rather than repair weaknesses' (Seligman 2002:5).

The programme is cognitive-behavioural in basis and uses a range of techniques to convey learning points, including: motivational techniques, e.g. open-questions, Socratic questioning, summaries, reflections, affirmations, group discussion, rehearsal (to consolidate learning), role-play; and cognitive restructuring (practising the use of replacement thoughts and behaviours). The therapy in the TC draws on a range of psychoanalytic perspectives and most of the residents have participated in cognitive-behavioural programmes in the past and so most of the group work techniques were familiar to them and caused little tension.

Therapists

It was thought to be important that therapists have access to additional supervision to manage any difficulties evoked by the content of the programme and how this may impact on the therapeutic alliance. Ackerman and Hilsenroth (2003) discuss a range of studies looking at therapist style and found that the therapist should demonstrate that they are working together with the client. The authors found that the therapeutic alliance was developed and enhanced through referring to common ground, something that may not be as straight-forward in this particular area of work. The therapist may find it difficult to show this when it comes to understanding deviant sexual fantasy and arousal

and so should work through these issues in supervision. The therapist should feel confident to undertake this work and have a thorough understanding of the role of fantasy so that they can feel able to be non-judgemental and empathic towards the client. Although this programme was devised by a psychologist, it was discussed at length with all members of the multidisciplinary team (as with all aspects of the work in the TC), and members of uniformed staff co-facilitated sessions when available. The culture of the TC was such that discussion of sexual and violent fantasy is the norm and so, whilst staff may require additional support, it is material they are used to dealing with.

Programme content

The programme consists of discussion on group guidelines, i.e. what each person might expect within the group, and the use of role-play looking at how they thought in the past and the alternate thoughts they can now generate. The Good Lives model is explained, with each participant applying it to current and future goals. A range of fantasy modification techniques is taught, including Directed Masturbation, described by Marshall (2006) as pairing arousal with appropriate images with masturbation thus reinforcing their excitement. Other techniques taught are: Covert Sensitisation (Marshall & Eccles 1996), a technique that pairs personally aversive consequences (such as being in prison, creating more victims, or being publicly humiliated) with each step of an offence-related fantasy; and Satiation, associating offence-related fantasies with boredom. There is discussion about what goods (in terms of Ward & Stewart 2003b) are achieved through fantasy, e.g. physical satisfaction (health), intimacy (intimacy), emotion regulation (inner peace), and how else they could be achieved. Each participant identifies what they have gained from fantasy and how these needs could be met in pro-social ways. There is recognition that it is easier to manage this arousal in the context of a prison than in the real world and plans were made to revisit this work with offender managers as they prepare for release.

The role of sexual preoccupation and using sex as a coping strategy is discussed and alternative strategies devised. The principal of urge surfing or distress tolerance (that is remaining in a state of arousal without reinforcing it through masturbation, with the knowledge that the urge will pass in a few minutes), and the use of thought stoppers as a means of managing arousal are also discussed and practised. For instance, one participant recognised the amount of time he spent thinking about sex during the evening and so planned activities to fill his time productively.

The programme also involved enhancing understanding of the victims' perspective, through the use of discussion and role-play with thought to how this would enhance knowledge and emotion regulation (inner peace). Role-play is used to explore the impact of current fantasy (sexual or violent) on a potential victim and to generate alternative thinking and behaviour. Participants found this a useful way through which to challenge cognitive distortions such as 'I'm not hurting anyone'. Placing themselves in the position of a potential

victim helped develop perspective-taking skills. One participant undertook a role-play placing himself in the position of a female in his fantasy and when he found himself in a similar position soon afterwards found that the memories of the role-play were immediate for him and he managed his thoughts appropriately.

There was discussion on developing intimacy and of emotion regulation (to enhance inner peace, and healthy thoughts) and developing a rich emotional vocabulary. The participants had the opportunity to practise expressing emotions such as jealousy and anger, and recognising the ability to manage own emotions increasing self-efficacy.

There was discussion of potentially risky situations in the future, rating them as green (slight risk), amber (raised risk) and red (imminent risk); and discussion on how they could cope at each stage, and about endings as the programme neared the end.

In line with TC principles, the ongoing work can be integrated into individual treatment targets and progress monitored through therapy.

The FMP in practice

On the whole, the feedback from the participants was that the intervention was useful in helping them to understand and manage their offence-related arousal. One participant concentrated mainly on violent thoughts and fantasies but also gained a good deal from the victim empathy module, as he had not completed SOTP previously and so not undertaken a victim empathy role-play. He was able to practise challenging ongoing aggressive thoughts emerging from current situations. One participant was concentrating on managing sexual arousal to thoughts of children and used directed masturbation to reduce the arousal to this stimulus. One participant concentrated on reducing his sexual pre-occupation and put plans in place to spend his time more productively and reduce the time he spent looking at erotic materials. One participant recognised the amount of time he had spent fantasising about children in the past, and how this had linked to his feeling inadequate and seeking to redress the power balance through fantasy. He used the satiation and directed masturbation techniques; this, along with developing his sense of self-worth through recognising his progress against his goals, increased his self-esteem. However, all of this will be ongoing work given the length of the programme.

Discussion

The programme was developed in line with research into group process and managing deviant arousal. One major drawback was the lack of an objective measure of arousal prior to and following the programme. Possible measures include phallometry or psychometric measures, but research (Marshall et al. 2006) highlights that such arousal is thought to be trait-based. For instance, if fantasy and offending happen within the context of drugs and/or alcohol use and numerous other dispositional and situational issues, 'it seems likely that

measuring their sexual preferences when they are calm and sober will tell us little about their offence related sexual desires' (p.88). The four participants on the pilot programme reported an increased ability to manage inappropriate fantasies and the desire to do so, but clearly ongoing monitoring will be required. Three of the four participants were due to be released soon after completion of the programme and so it was thought necessary to increase their skills in the area of managing offence-related arousal. Each participant recognised the amount of time they had spent fantasising and how this helped them to escape reality and feel in control and developed alternative strategies to feel empowered as the programme progressed. As this programme is designed to run within the context of ongoing treatment, evaluating it as a stand-alone intervention is problematic. At present the only measure of change is self-report, which may be open to question, and so further measures will be sought, possibly including a card sort or suitable psychometric tests such as thematic apperception tests (Aronow et al. 2001) as they can be assimilated. It is hoped that the programme can be flexible to the needs of its participants and used to help them to address this treatment need.

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Personal Reflection

First Years in the Daytop Therapeutic Communities, Germany: Personal Point of View on the Development of a Concept-Based TC for Substance Abusers in Germany

Martin Däumling

First years in the Daytop TCs in Bavaria (1975–1990)

I started my engagement in the therapeutic community movement for drug substance abusers in Fridolfing near Salzburg.

This was the first Daytop TC in Germany founded by the priest of the Orthodox Church of Romania, Ulrich Johannes Osterhues. He asked me in 1975, when I had finished my Diploma in Sports and Psychology, to go to the south of Bavaria in order to overcome my never-ending promotion effort following the 68-student movement. I never thought that this change would have led me to a more-than-30 years' lasting engagement in the treatment of drug addicts.

The ten residents of Fridolfing lived in a small farm outside the village. Besides one colleague, Günther Haufe from Meran, who was a great believer in the Antipsychiatrie in Italy (Basaglia 1973), there were only two elder addicts who had just completed the programme that formed the staff together with me. Five of the residents in the mentioned group later worked as leading staff members in different Daytop TCs in Germany.

The concept and idea of the treatment was also influenced by the American Daytop Philosophy as well as the humanistic approach in psychology in Europe and general society. Awareness, intensity and totality in the 'Here and Now' were more important than perspectives and strategies. Gestalt Therapy (Perls 1978), human growth movement, Dan Casriel's new identity process (Casriel 1975) and Janov's 'The Primal Scream' (Janov 1970) were some marks that influenced the self-understanding and the practice of the staff members.

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The contact with the residents in these times was very personal and without much distance. On the other hand the residents were expected to change their behavioural patterns and their outer appearance radically. For example, they were asked to cut their long hair during the intake ceremony in the TC. Often there were encounter groups for hours in order to convince a resident not to quit the TC.

In the first years there were four events that I remember and that became in a way important for the further development of my understanding and acting in the TC movement.

- The staff members of the TC Daytop Fridolfing and the TC Daytop Emmering/Fürstenfeldbruck decided to visit the Emily Hoeve TC in The Haag. Martien Kooyman introduced us with the meaning of 'from chaos to structure'. We were impressed by the new guideline and the high standard the residents did their jobs.

  Martien Kooyman was in these years and later on one of the most important leaders in the practice and understanding of the treatment of drug abusers (Kooyman 1993). An amusing side-effect was that one staff member of our team the next day was convinced by a Dutch colleague to cut off his beard in order to behave credibly to the residents in his TC.
- Another important event was a marathon held by Denny Yuson in the Daytop TC Schloß Gessenberg in Bavaria. For 24 hours all members of the marathon stayed in one room and shared experiences like active meditations, encounter sessions and lectures form the 'guru' Denny Yuson. The authentic and indisputable inside knowledge of this pioneer made us feel insufficient and on the other hand supported by the politics of sanctions and privileges and the attitude of total dispense. It was a great show in retrospect.
- A third important influence for me personally was a workshop with Dan Casriel in Bad Herrenalb. 'A scream away from happiness', including the bonding psychotherapy, became a guideline for my work in the next years.
- In 1977 the Daytop facility moved from Fridolfing to Oberpfaffenhofen, near Munich. We started to build up a new TC. In this year Monsignor O'Brien, the president of the World Federation of Therapeutic Communities in New York and co-founder of Dayton in the USA, visited the TC. He was welcomed with great emphasis and some American songs. I never will forget my irritation when Monsignor O'Brien asked me, after some small talk with the staff members, 'Where is the family?' I wondered why Monsignor wanted to see my wife and my daughter. It lasted some moments till I realised his understanding of the connotation of family. Till nowadays 'family' is an often-used description of the residents' group and their own slang.

At the height of the Daytop career (1990–1998)

My first contact with a TC outside Germany, together with a Canadian colleague who worked with me in Daytop Germany, was a visit to Phoenix house in

London in 1976. Strategies of Behaviour modification and rituals felt still strange to me.

Two visits in the USA in 1990 and 1998 with longer stays in the Daytop TCs in Springwood, Swan Lake and Millbrook influenced my understanding of the TC philosophy and the programme; in addition, I more clearly understood the differences between the cultures and the idea and practice of the treatment of addicts.

From 1989 to 1994 the Daytop organisation elected me as chairman of the scientific advisory board of the Daytop incorporation (wissenschaftlicher Beirat der Daytop Gesellschaft). Once a year I organised a local congress or meeting with German researchers about some aspects of the diagnosis and the treatment of addicts. The dealing with residents that were affected with the HIV virus was at that time one of the main issues.

Together with a colleague of a Daytop TC in Berlin, Hartmut Oberdieck, and Prof. Deinhardt, the Director of the Pettenkofer Institute in Munich, we could ensure that HIV residents were not excluded from the TCs. We developed standards to interact in a responsible and safe way. It was an important achievement that I, together with my team, refused the idea of building up a special treatment centre only for HIV-positive residents. Looking back, to cope with this challenge gave the TC movement a very strong power and estimation.

In the 1990s I got to know a lot of TCs in Europe in Switzerland (Aebbi Hues; Arxhof), Poland (Monar; Gliwitz; Lublin), Tschechien (Prag, Olmütz); Spain (Marbella) and of other organisations in Germany. These contacts and a lot of visits to our TC in Grafrath formed and developed my concept and view of our TC style.

Further development with the Deutscher Orden, a public corporation (1997–2007)

In 1997 there was a big change. Ulrich Osterhues passed about 50 rehabilitation Daytop, Phönix and Seca centres into the hands of the 'Deutscher Orden', which meanwhile had become a public corporation. The president of the DO is the Prior of the order. The headquarters of the Order is in Weyarn, a monastery 20km south of Munich. The leading managers for the addiction help department now have their office in Bad Orb, near Frankfurt.

After some years, the Deutscher Orden nearly collapsed, because the then prior and leading managers of the order shifted to megalomaniac ideas and transactions. The Bavarian government, the catholic diocese of Munich and the power of the staff of the TCs saved the survival of the treatment centres.

Meanwhile the consolidation of the organisation with a new leading team and reorganised structures is nearly completed.

In the self-understanding and the practice in the last few years there has been a diversification and differentiation. Some TCs did move to a more clinical approach, with the effect that the therapeutic community is merely regarded as a (powerful) setting. Some other treatment units, especially the sociotherapeutic treatment centres, kept and saved the TC philosophy and some rituals. The

rehabilitation centres received many instructions from the insurance systems that pay for the treatment: for example, the necessity for medical directors, a maximum of treatment time up to 26 weeks, a quality management, scientific documentation systems, a list of educational standards for the engaged staff, and a minimum of residents in one building (clinic). Following these standards it is clear that the practice and the self-understanding must shift to a professional level.

We had to make arrangements, during which I came to see and cope with the advantages of the new challenge. One of the most remarkable positive effects is the diminution of the dropout rate. One of the most critical issues is the short duration of the treatment and the lack of group coherence. TC encounters with all residents happen seldom. Confrontation is only one form of communication. Emotion is expressed in one-to-one therapy or in small therapeutic groups. Time goes by. Staff members that have their own history in overcoming addiction changed their style and attitude.

In saving and estimating our history, the Grafrath clinic has now realised (after five years of preparation) an enlargement. A new building was opened in the late summer of 2006 in order to take in treatment up to 37 addicts. Writing these lines I realise the permanent change in the TC movement over the years and decades.

I remember wonderful meetings and solidarity with many colleagues in other countries that have had a lasting effect on me.

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An Open Letter

When the Political is Personal: A Complaint Called Henderson

Martin Weegmann

I was at University at a time when feminists proclaimed, 'the personal is political', a powerful formulation that shook complacency, inviting us to question the worlds we inherit and internalise. Years later, Judith Herman (1992), writing in the context of trauma, credits feminism for helping to challenge oppression, for insisting that power misused against women must be exposed and with it the internalised oppression that helps the powerful to believe that nothing is wrong, they can act with impunity, etc. She makes the interesting observation that whenever large-scale trauma has been exposed in society, it has been in collaboration with a political or socially-aware campaign; republican, anticlerical movements in the case of hysteria, anti-war or veteran mobilisation in the case of shell-shock or combat neurosis and feminism in the case of sexual or domestic violence.

The Henderson arose from the ashes of war, in a world that demanded change: welfare 'from cradle to grave', greater egalitarianism, 'goodbye to all that' and so on. The desire to change the world however should not be over-stated – there was plenty of conservatism too, 'making do', holding on to the 'British way of life', even a reassertion of older imperial and patriarchal values (see Adison's 1985 appraisal). Far from expressing a widespread 'people's psychiatry', as it were, Henderson was the product of a radical *moment* rather than a revolutionary movement – a minority group of staff who identified with critical, questioning values. 'Social drifters' and 'misfits', unable to adjust to civilian life, were hardly a popular constituency and so had few champions. I was amused by an anecdote reported by a visitor to the early Social Neurosis Unit, who, on asking a workman the way received a curt response about Max's hooligans and how they *really* should be treated (Briggs 2002)! Trauma and displacement born of family life, when family was meant to be the warm, idealised hearth, was difficult for society to acknowledge; 'psychopaths' were an easy target to invalidate. Not surprisingly, the Henderson faced strangulation at birth – the Board of Management at the time wishing to terminate the

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therapeutic community; Jones (1968:38) reflects on this first survival fight, 'I faced this committee alone and found it one of the most traumatic experiences in my life, mainly because I was seen as the dangerous and deviant leader who was threatening the effectiveness and security of the parent hospital.' A second committee of inquiry descended a year later, although Jones did not face this one alone. Closure threats and prevailing political climates are part of our history, for good or ill.

On joining the Henderson (2005) I felt like a fish out of water, as if all that I had done before no longer counted. It put me in touch with things internalised – a fear of not having an impact (whilst desperately wanting to), does my voice carry any weight? What authority do *I* have? The conservative culture of origin I was brought up with said things like: fit in, conform, don't create a fuss, respect elders and betters and the echo chamber was working overtime. Yet I also reconnected to the young radical within me, to the very values that attracted me to the Henderson in the first place. It was all about inner 'world changing'. As for parallel process, one of 'my' groups was for new residents – helping them to acclimatise, overcome what I used to dub the 'admission crisis' ('Oh God, what am I doing here?') and gain appreciation of our rules and ways of being together. Recalling this group feels like a cherishing of memoires, reminding myself of the simple yet evocative appeal of Henderson values and treatment. How to help people to move in, actually and metaphorically?

Two examples from the group: I often inquired, 'How do you find the place, your first impressions of the building and people?' Shocked reactions often followed (both disguised) – one person said, 'it makes me want to catch the first train out of here, it looks like a psychiatric dump' and another said, 'it's quite a nice building, better than I thought. Kinda takes me back to university halls, which was quite a good time in my life.' The first person stayed, against the odds, resisting a powerful urge to flee to the familiar and thus stifle any prospect of learning from the new. The second resident hit a crisis after month one, the first of many, overwhelmed by the extent of his difficulties and terrified of asking, let alone allowing 'strangers' to help. His confidence grew in time and he was able to use his educational skills very productively within the community; living and learning, acting-out and refusing, all part of the oft repeated cycle. Both found voice, stronger voice. And so did I – one discovers or re-discovers a sense of authority. I guess we all slowly challenge unproductive things within ourselves – messages and voices internalised or with which we have identified. TC's like the Henderson address root experiences (from which the term 'radical' stems) and in so doing clear the ground for alternatives, e.g. being able to ask, to admit vulnerability, to give voice, to protect.

What of public versus private grief? I could not write this article without acknowledging the incredible strains of the last year, up to the 'temporary' closure of April 2008 – and dispersal of Henderson staff. For us, it is about jobs and preferences about where we choose to work, but for clients it is about access, or lack of it, to treatment. Two things stand out from the year, in terms of the impact of our decline: firstly, unfortunate dilemmas of communication and, worse, a process of reversal. As our fortunes dwindled, how much to

inform residents about the commissioning climate, reduced referrals, the political? We both shared information and held some developments to ourselves, walking a judicious tightrope. Our residents were there for treatment, so how much to disturb their relative security with our incremental, bad news? Should the parent tell the kids that the factory might close, when it might not? It was a no-win situation and residents soon read us and responded accordingly. Reversals did occur, with residents unconsciously looking after us, holding back their anger, sparing the staff, but not always. Who was most in need of whom? Accusations were also present – what were we doing to save the place, what were our errors, etc? A safe base became, at times, an unsafe, even, counter-container. Worse, to new prospects, were we prescribing insecure attachment? Elsewhere I have reflected on how a vibrant culture of inquiry was replaced, insidiously, by a culture of survival (Weegmann 2008).

The second, related to the first, concerns reality orientation, a value we all cherish. How could we assess the reality of the threat that eventually came to pass, with temporary closure? Feelings fed perceptions of reality. How could they do this to *us*? Since we had faced so many threats before, surely one more did not matter? At times, I admit to the magical belief that, if we just all felt passionately enough (which we did) and reminded ourselves of our legacy, we could avert closure. I am not suggesting anyone was lost in delusion, but that we all struggled to judge the gravity of what was happening. History has taught us that TCs are able to climb onto 'magic mountains', clinging to illusions of permanence and rebuttal of a hostile world (Van den Langenberg 1985) Some clients may have believed this as well, but not all. Parallel process again?

As our situation became known about and increasingly shared, the private and local shaded into public protest and grief. It was hard receiving sympathy from so many others, on my journeys, but also hearing echoes of what some residents asked. Did we do enough? Others believed we had had a long enough innings and that the Henderson failed to change sufficiently to suit the modern world. Why should the Henderson think of itself as so central anyway? It is hard to get a perspective on grief when one is in the middle of it. It is hard to face the erosion of an illustrious history and accept the current deal: no TC, no Outreach, but a small core team with an uphill task and a prolonged public consultation. Loss through dispersal of incredibly talented colleagues is another sorrow story.

So what of the political within the personal? The new climate talks up the local and the day. Is time, our era, against us?

Wither specialist residential units? Are we in a realm of the post-TC? I feel a complaint called Henderson, but do not want to be trapped in complaint, to bemoan. But it hurts that, within a decade, a national expansion has become a national contraction. Will there be a Henderson Two, or will all our achievements become a memory, a 'cloudy trophy hung' (Keats)?

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Obituary

Richard Wilfred Crocket: A Professional Biography[1]

David W. Millard

He was known to his Scottish family as Wilfred, but professionally – and universally within the therapeutic communities movement – as Richard. Shortly after Richard Crocket's death (aged 92) in December 2006, the Editorial Collective invited me to provide an obituary. At the time I accepted, I had overlooked the fact that much of the information normally included in such a thing had already been sensitively placed on the record in this journal by Craig Fees in 2003 so I came to the view that it would do no service to Richard, or indeed to Craig, simply to repeat material already available to many readers (Fees 2003). Rather, what follows is an attempt by one who counted Richard Crocket a long-standing friend to review his place in the development of therapeutic community theory and practice. In some ways, he is representative of a particular group of psychiatrists of his generation; in others there are obvious contributions worthy of record that were specifically his own. He exemplifies an insufficiently recorded phase in the history of the therapeutic community: the crucial contribution made by the mental hospitals, now almost completely disappeared from the British psychiatric scene, in preserving the therapeutic community model, developing and transmitting it for use in the rather different settings we have today. His collected papers are available at the Planned Environment Therapy Trust Archive and Study Centre and I have drawn extensively upon them for this account.[2]

[1] Richard Wilfred Crocket: MBChB Glas. (1937), MD (1965), FRFPSGlas (1942), FRCPEd (1962), FRCPGlas (1970), and FRCPsych (1971). Born 9 February 1914, died 3 December 2007.

[2] Planned Environment Therapy Trust Archive and Study Centre, Church Lane, Toddington, Glos. GL54 5DQ.

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Preparation

In common with most early therapeutic community practitioners, it is impossible to separate entirely the story of the development of Crocket's personal understanding from that of the institutions with which he was associated: principally, the Ingrebourne Centre of which he was Medical Director from 1954 to 1977. He went there in mid-life, aged 40.[3] What, then, did he bring to this task?

First, of course, we must record some of the abiding characteristics of the man: his quirky style and impressive intelligence. Accepted – as Fees' 'Introduction' (2003) records – by Glasgow University for admission at the early age of 16; later a sufficiently distinguished junior academic in the University of Leeds to have reasonably anticipated appointment to the Chair (as he confided to a close colleague and friend, St. Blaize-Molony 2007); he was a prolific and rapid writer and widely recognised in the therapeutic communities' movement as an incisive, tenacious but invariably courteous controversialist. Also, he was intensely curious and inventive, with a wide-ranging interest in the *structure* of things. Among many examples are the suggestions that Crocket had made about various design flaws to Alec Issigonis, the designer of the British Motor Corporation's Mini, some of which were adopted (Perry 2006), and, after his retirement to Oxford, proposals for the local bus system and various town-planning projects, as well as bringing to completion a highly original and successful reconstruction of the interior of his own home. The development of the Ingrebourne Centre was itself in many ways an example of this inventiveness.

Those who knew him well share – I suspect, virtually unanimously – the perception of a complex, indeed contradictory, personality. On the one side, as his long-term colleague and friend Christopher Perry recalled in his address at the funeral:

> A quiet warmth suffused every encounter with him … he was generously hospitable … and a man of great inner integrity, wisdom and compassion.
>
> (Perry 2006)

And many will remember his resistance to compromise, his unswerving obstinacy over matters of principle, and deep honesty. But, despite this self-confidence, he could nevertheless worry obsessively over some detail of the task in hand – for instance, re-writing endlessly some academic paper – to the point of infuriating his colleagues. He wrote, indeed, with crystal clarity but his verbal communications, both in professional and social contexts, could be opaque, and often impishly oblique and challenging.

The second element in Crocket's preparation for the work at Ingrebourne lay in the pathway he chose for his professional training. This included two

[3] Coincidentally, also the age at which Maxwell Jones moved to the Henderson; these were clearly men at the height of their powers! (cf. Millard 1996).

essential elements: a thorough grounding in psychodynamic psychotherapy and a persisting commitment to an academic approach to psychiatry. Fees' biographical Introduction (Fees 2003) gives greater detail, but we may summarise here. The former includes, before 1940 and his wartime service, four years of junior experience at Gartnavel Hospital – where his immediate colleagues included a number who later became distinguished psychoanalysts[4] and where '... my subjectivity came home to roost' (Fees 1998). This was followed by a year as a locum psychotherapist at the Cassel Hospital. The informal acquisition of a good level of psychodynamic sophistication, and its later applications in practice, was commonplace among those psychiatrists of the time who were so inclined; indeed, apart from the analytical Institutes, no other training was available. On the academic side, Gartnavel had a strong academic tradition, and his experience from 1950 to 1954 as Tutor in Psychiatry at the University of Leeds, with the associated Senior Registrar post at the Infirmary, gave him a lasting foundation and the opportunity to publish his earlier papers which were on general hospital psychiatry and psychosomatics (Crocket 1943, 1951, 1952).

Early years at Hornchurch

In 1954 he was appointed Consultant in Psychological Medicine jointly to Oldchurch Hospital, Romford, Essex and St George's Hospital, Hornchurch, the latter becoming the locus for his major contributions to theory, practice and research in the therapeutic community. But, typically for the time, the breadth of the duties attached to the appointment included, as well as general adult psychiatry, responsibilities in liaison psychiatry, child psychiatry and psychogeriatrics.

He took charge of a traditional acute psychiatric unit, 'Ward 3G', later renamed the Ingrebourne Centre for Psychological Medicine (after the name of a stream running through the grounds). It had previously been an offshoot of Warley Hospital but '... its small size and distance from the parent hospital made it a problem child.' In 1954 it became an independent psychiatric unit and came under the administration of the general hospital group in which its buildings were situated. Crocket set about liberalising the regime. This process remains unusually completely documented, both in respect of the institution and in tracing that stage of his own professional development.

The institutional development is well described in the reports on the Ingrebourne Study (1961 and 1965) to which I return below. Until the introduction of the psychotherapeutic community methods the unit was organised on the pattern of a traditional short-term mental hospital admissions ward. Although described as a neurosis centre only about half of the patients were suffering from the effects of psychoneurosis, as was then commonly the case. In 1955 a day-patient system was put in use '... bridging the gap between [an]

[4] They included Jock Sutherland, Henry Ezriel (both later on the senior staff of the Tavistock Clinic) and Susan Davidson.

emotionally regressive climate which is inclined to develop inside hospital and the basic external social environment' (Crocket & Hassell 1961); and, by 1957, 20 day-patient places (accommodating 40 patients) had been added to the 20 beds. In 1957 a Psychotherapeutic Social Club was set up three miles from the hospital in rooms belonging to the local British Legion, and there was later a second Social Club. Fees' account mentions Crocket's own characterisation of the resulting network: '… a kind of Jungian picture, I suppose, of a centre with ramifications amongst general practitioners and hospitals functioning as an exchange rather like the telephone exchange' (Fees 2003). The ward regime retained for a time the use predominantly of one-to-one methods of treatment (including brief experiments with the therapeutic use of hallucinogenic drugs) (Crocket 1963) but also began some tentative experiments with weekly small-group therapy. However:

> It was only with the appointment of a full-time senior psychiatrist in July 1956 that the move to a full therapeutic community approach developed. (Crocket 1957)

This vital moment refers to the arrival from Dingleton to a newly-established SHMO post of a fellow Scot, Hamish Anderson, which stimulated the addition of large group methods and the evolution over the following few months of a fully-fledged therapeutic community. Crocket acknowledged Anderson's contribution in several publications; but he is a little known and transient figure in the history of therapeutic communities. His essential importance to us is his influence on Crocket personally and the Ingrebourne Centre (Millard, in preparation). Anderson is credited with the introduction of social group methods:

> … which he had known at Dingleton Hospital, Scotland. The results were so stimulating, not to say startling, that the staff became committed to these methods. At first they knew them as their own venture into social therapy. Then came information about Dr Maxwell Jones's activities at Belmont Hospital; and we realised that by a different route we had stumbled upon what was beginning to be known as a therapeutic community. (Crocket 1997)

Crocket's own availability as the consultant was initially three half-days per week, but in practice later rose to five half-days. His self-description at the outset is recorded by Fees (2003): '… a very traditional and proper kind of figure, … orthodox [and] academic in a kind of detached, intellectual way.' But Crocket recalled the incident of his conscious tolerance of a patient who had dismantled a motor cycle in the highly-polished ward environment as a trigger to his becoming 'a convert to Hamish Anderson's groups' in which he began to take a personal part.[5] Between July 1956 and April 1957 a very significant development occurred. Anderson had introduced large groups on his arrival, but his own attendance and that of nursing staff members was at first irregular – other clinical commitments were allowed to take precedence. It was only after

[5] Interview with Craig Fees (1998). PETT Archive, Toddington, Glos.

rethinking the arrangements so as to allow Anderson himself and, as seems implicit in the records, Crocket and other staff members to become *regular* participants in the groups that the regime began to succeed. And it is from this structural change in 1957 that he dates the establishment of the psychotherapeutic community. By November of that year Crocket was able to present a lecture to the Runwell Hospital Medical Society on 'The Therapeutic Community Approach in a Neurosis Centre' (Crocket 1957) – a relatively early example of the adoption of the method outside the specialised hospitals such as the Henderson or the Cassel. It is possible to sense his personal development from psychiatric generalist to therapeutic community specialist from this time.

The Ingrebourne Study

No doubt partly as a consequence of the challenge by the authorities to the lack of any evidence base for the regime, Crocket conducted an empirical study that reported on the treatment and results in a cohort of 68 Ingrebourne patients between April 1957 and March 1959. This work is not widely known, and is described here because of its historical significance. The point is that it was in progress during the same period as Rapoport's famous study of the Henderson, published as 'Community as Doctor' (Rapoport 1960). Crocket's findings were reported to his funding body, the North-East London Regional Hospital Board, in 1961 but they appear not to have become publicly available, at least in a comprehensive form, until he submitted his MD thesis in 1965 . Accessible only through libraries, this is of course an obscure avenue of publication – suggesting, perhaps, that he thought of this work more as a political bargaining tool than an academic contribution. Nevertheless, it is clear that Crocket was aware of the importance of numerate, evidence-based, work and was active in this field as early as the Henderson team. Manning (1989) and others are certainly correct in asserting that Rapoport's studies had a profound influence within the therapeutic community movement, but as pioneer quantitative work they are evidently not quite unique. This is the only example known to me of comparable British work dating from that time, but it would clearly be important to discover any others.

The detailed findings of the Ingrebourne Study are nowadays mainly of historical interest, but worth summarising for the public record. The intention was to provide an overall assessment of the success rates for treatment in the psychotherapeutic community regime. The method was to be by interview conducted in the patient's home after discharge, using separate versions of a structured questionnaire for the patient and relative or close friend, and supplemented by the researcher's impressionistic account written up as soon as possible after the event. Christine Hassall[6] was appointed as research assistant and conducted the interviews. Of the 638 referrals to the service over the two-year period, 454 had been accepted for treatment, of whom it was deemed

[6] Christine Hassall later contributed extensively to research in the mental health field in Birmingham, the Worcester Development Project and at the Institute of Psychiatry.

practicable to interview 100 selected using random tables (Moser 1958). The sample was reduced to 80 by excluding children and adolescents (9), out-patients referred only for ECT and always admitted elsewhere (6), patients still under treatment (5), and by a further 12 who could not be contacted, including five untraceable and two who refused. The 68 ultimately interviewed (39 female, 29 male) comprised, in the terminology of the time:

Psychoneurosis	47
PD and psychopaths	6
Schizoid/paranoid pers.	2
Depression	7
Alcoholism	1
Psychosomatic	2
Other (organic)	3

This is probably reasonably typical of the diagnostic spread found at Ingrebourne during Crocket's time with the unit.

Considerable thought was given to the categories by which the overall state of the respondents could be defined, Crocket finally selecting a set of definitions originally described by Harris in the 1930s and then recently re-published (Harris 1954, 1955). This yielded four categories based on occupational competence to which the researchers added subjective counter-parts that turned out to correlate well (Crocket & Hassall 1964), as follows:

Grade of severity	Harris's objective criteria (Assessable by a non-psychiatric observer)	Crocket's subjective criteria
1	Unable to pursue occupation; economically inactive	Feels very ill
2	Able to work and earn a living, but forced by symptoms to modify their lives considerably, resulting in much limitation in interests and activities	Feels quite well but can manage to some extent
3	Able to lead full active lives but at times seriously inconvenienced by symptoms	Feel not too bad, but does not feel well
4	Free of symptoms and apparently well	Has no symptoms and feels well

These grades were allocated on the basis of patient and informant self-report made at the time of Miss Hassall's post-discharge interview, and are thus retrospective for the patient's state on admission and at discharge. The findings were:

Severity	Grade on admission	Grade at time of discharge	Grade at interview
1 (Ill)	38	9	5
2 ↓	27	31	17
3 ↓	3	21	29
4 (Well)	0	7	17

Crocket's report notes that this method did not allow the use of a control group, but he does offer a comparison of these results with the small number of studies of psychotherapy available at the time (Eysenck 1960:712). He offers various comments on the outcomes:

> This figure [i.e. 60% improving from Grades 1 plus 2 to 3 plus 4 at discharge, rising to 79% at the follow-up interview] … compares well with the others quoted; and it is certain that the criteria have been more stringently defined and applied than most. (Crocket 1965:74)

> The results of therapy in this unit do appear to be at least equal to the results reported from traditionally conducted units in the past. (Crocket 1965:75)

He notes the evidence for continued improvement of the surveyed group following discharge; the increased efficiency of the service in terms of the number of patients treated within the unit; the improvement in staff interaction resulting from the introduction of the therapeutic community approach (Crocket 1962a); and also benefits such as the abandonment of night sedation (decided by '… a heated and confused community group discussion …' against the prejudices of the staff). He also proposes a mechanism to account for the success of the unit:

> It appears to be the deliberate process of 'structuring' the use of time, combined with the skill in the conduct of therapeutic relationships of a traditional kind, but modified to operate through an affective contact with the community as a whole rather than through one-to-one contact, which marks the therapeutic community approach. (Crocket 1965:78)

He suggests the potential relevance of this approach to the conduct of social groups among the population at large.

In addition, alongside this work there was a study surveying the attitudes of general practitioners, whose patients had been treated, '… directed to the wider issues of their attitude towards the service as well as the success or failure of treatment as such' (Crocket 1965b). This was reported separately (Hassall & Crocket 1962).

With 50 years' hindsight, it is certainly possible to be critical of the Ingrebourne Study. For example, few surveys nowadays would accept ratings of the patients' condition made retrospectively rather than at the time of admission or departure, or a follow-up carried out at an unspecified interval

following discharge. And yet, this is clearly a responsibly conducted investigation: it was unusual for its time, and largely unrecognised within the therapeutic communities' movement. Nevertheless, I suggest it carried a certain influence. That influence surely lies in the background of confidence it must have provided, evidently for its sponsors, the Eastern Regional Hospital Board and the referring GPs, but also for Crocket himself and probably others who worked at Ingrebourne. The 1960s were a time of optimism for the therapeutic communities' movement; it had yet to enter the phase of what Nick Manning has called the 'legitimacy deficit' of subsequent decades (Manning 1989). But the charismatic leaders, of whom Crocket was certainly one, were not entirely without objective evidence for their conviction that these new methods actually *worked*.

The middle years

Returning to the next stage in the evolution of the Ingrebourne Centre and of Crocket's personal progression towards greater degrees of specialisation in therapeutic community practice and theory, he began surrounding himself with colleagues of substantial psychodynamic expertise. Several of these were moving towards psychoanalytic qualification or had already been elected to one of the Institutes. Among them, I single out Ronald St Blaize-Molony who has contributed his recollections very generously to this account (St Blaize-Molony 2007). He joined the Ingrebourne Centre in the late 1950s, initially as the SHMO in succession to Hamish Anderson, and takes up the story at that point, noting particularly Crocket's support for the staff:

> He [Richard Crocket] was clearly aware of how at sea I was in those early days. My position was relatively senior and therefore a responsible one clinically and one to which the community looked for therapeutic leadership. At that time I had no acquaintance with groups other than as an adjunct to occupational therapy and no idea of the community as an all embracing therapeutic concept. My personal analysis had barely got itself underway. The community was in a state of huge bereavement (staff and patients) subsequent to the departure of two much loved charismatics [one of them, Anderson] who were very experienced and therapeutically deft. The transference was negative to the point of critical hostility expressed in sullen silences and extravagant acting out. Richard was justifiably uneasy; even alarmed. This, especially since his was a very part-time appointment, much of it taken up in administration. Thus his own attendance at groups was sparse and in the circumstances not reassuring for him. To his eternal credit he had the massive self-restraint never to intervene and show me up. Nor did he undermine me at staff meetings. … Richard organised with the director of the Tavistock Clinic for me to attend weekly behind a one-way screen at his psychotherapy demonstrations with a therapeutic group. I profited immensely and I like to think quickly.

Reflecting on the departure of Hamish Anderson, he notes:

> Certainly he [Anderson] was remembered at all levels with great affection, leaving many transference residues. Although Richard described himself as owing 'a deep clinical debt' to Hamish, I have inklings that he was interested in social contexts and interactions before their Ingrebourne encounter.

And on Crocket's therapeutic style:

> Not only did I learn from my Tavistock times, but Richard's gnomic utterances at staff meetings proved a catalytic boon. The downside to these was staff bewilderment and insecurity. My anxious responses pushed me into the role of mediator. I found myself explaining Richard to staff. This developed my own thinking and helped me enormously. Richard tried out his own thinking on us for use in the many papers which were pouring out of him.
>
> Certainly staff – especially those who had come from traditional mental hospitals – considered he was outlandish in his thinking and the ideas he presented for them to ponder and make sense of. … His conformism did show itself in one of his *dicta* – the more 'way out' you wanted to be with groups, the more formally and conventionally you must present yourself; not least in the matter of attire. This last was something I did note had changed radically in the 'after-life' of the Centre. There came to be total identification of staff and patients, the intention of a radical approach was signalled by a somewhat bohemian dress code. Richard felt the centre was gradually giving priority to staff feelings and priorities. It was obvious he deplored this. This aspect of conformity enabled a good relationship with the parent hospitals, Regional Board, and outer society. Perhaps it was his ability to hold these splits together which enabled him to contain and make use of the different voices which he had to orchestrate at the Ingrebourne Centre in and over time. (St Blaize-Molony 2007)

St Blaize-Molony then refers to 'one event which did give him [Crocket] confidence which was a challenge to the existence of Ingrebourne, …' – and (describing the Ingrebourne Study outlined above) concludes:

> This episode, I think, made his thinking more confidant. He began to talk about knowing the answers (though still never revealing them) rather than asking the right questions.

He continues with this reflection:

> My impression is that he regarded agnosticism as the only valid position for those who paid tribute to science – its methods and findings. He seemed to believe that whatever would lie behind any success in psychotherapy must forever remain a mystery. I think he saw it as an aim of treatment to splint in as humane a way as possible fractured personalities by creating optimal emotional and social conditions of interaction. He did not minimise the counter-transference and once declared provocatively that 'if the psychotherapist is happy the patient is doing

> well'. Via the *vis medicatrix naturae*[7] being released patients would be enabled – to paraphrase Freud – to become as well as they were capable of being.
>
> (St Blaize-Molony 2007)

There are perhaps sufficient hints in St Blaize-Molony's clinical and personal anecdotes to point us towards some of the theoretical ideas that Crocket was evolving at this time. First is the concept of the 'psychotherapeutic' community, of which his definition appears in several publications:

> a consciously contrived large group of people made up of patients and staff, to which both patients and staff are expected to relate for therapeutic purposes rather than to an individual therapist. (Crocket 1964)

His point is to differentiate this from a 'therapeutic' community which is also a consciously contrived large group of people 'through which individual treatment is supplemented as far as possible by psychotherapeutic community relationships' (Crocket 1964). This distinction is, of course, similar to that of David Clark between the therapeutic community 'proper' and the therapeutic community 'approach' (Clark 1965) and it encapsulates Crocket's commitment to a definition of the method exclusively in terms of *groups*. It follows that, if, effectively, all the transactions of therapeutic importance – the gradual assembly of information, progressive understanding of this (including transference and counter-transference mechanisms), interpretation, working thorough the matters that then arise, and the growth of insight – are thought of in terms of the patient's relationships with groups, then the *structure* of groups, their membership and conduct become matters of the highest significance. Much of Crocket's later thinking is to do with such structural issues, and his approach to these rested heavily on his use of systems concepts, especially social network theory.

Crocket's differentiation between 'real 'and 'abstracted' social networks was well summarised in his contribution to 'Therapeutic Communities: Reflections and Progress' (Hinshelwood & Manning 1979). This chapter ('The therapeutic community and social network theory') is a good illustration of his intellectual habits. It begins with some reductionist reference to the physical, neurophysiological substrate for human relationships, and proceeds through cultural anthropology (where, with Lévi-Strauss (1969) and others, the notion of social networks originates) to his own original proposal. The starting point is that:

> What anthropologists and sociologists actually do is to look at a particular social field and abstract from it relationships they are particularly interested in. They then consider these relationships as if the connectedness involved constituted a physical network … (Crocket 1979:131)

[7] The natural power of healing (from the Hippocratic collection of writings where the emphasis is that illness should be conceptualised in natural, as opposed to supernatural, terms – however imperfectly these may be understood).

Where these relationships have a network meaning, he describes them as 'abstracted' networks. But this, he argues, 'has only limited value for the institutional therapist, whose aim must be to understand the total structure of the community he is concerned with, and which he is determining' (p.131). Thus:

> The term 'real network' can usefully describe … the total and actual physical relationship movements and mutualities, in space and time, which we create in a therapeutic community. (Crocket 1979:131).

There follows an exposition of this in terms of power and decision-taking, authority and permissiveness, and boundaries that leads to a consideration of therapeutic communities as part of a wider 'social network-at-large' (p.134). The exercise of these functions is, Crocket suggests, to be seen at all levels of social structure from the Ministry of Health (as it then was) down through local NHS organisations to the individual therapeutic community, the elements within it, and the actual therapeutic confrontations that, it is to be hoped, result in the resolution of the psychological and social problems which brought the individual patient there in the first place. Indeed, this model may be carried to a deeper structuralist level – an intrapersonal level – within '… the traditional concepts of psychotherapy and psychoanalysis (in all their forms) …' (p.137), which he briefly exemplifies in object-relations terms. The paper oscillates between a consideration of real events in the therapeutic setting and highly abstract, but suggestive, theoretical reasoning which is the hallmark of Crocket's particular contribution to this stage of the evolution of the therapeutic communities' movement and which reappears in much of his later writing.

The translation of this 'structuralist' approach into research proposals (of which he was a notably fecund source) involved identifying the relevant boundaries that Crocket thought definitive of institutional social structures: territory, time and membership.

> I proceeded by listing as many oppositions that I could think of in relation to clinical practice in the Ingrebourne Centre, e.g. being early for a group, being late for a group; talking continuously during a group, not talking in a group; arranging one continuous large group using up all the available time, dividing the time available in maximum one-to-one sessions; being directive, being permissive; etc. I stopped the listing of oppositions when I had about 55, and then proceeded to assimilate each one into groups that gradually coalesced into three basic abstract categories. These were, first, being directive and requiring immediate conformity with the exercise of authority as against being permissive and non-directive in the exercise of authority; second, maximising the use of group transactions in which the membership could see and hear everyone else and so minimising physical divisions within the treatment community, as against maximising the physical division in relationships, with consequent proliferation of one-to-one transactions; and, third, the looseness within which structural boundaries were used as against the rigidity with which they were maintained. (Crocket 1975)

It will be clear that this approach generated a huge number of potential research questions – all grounded in a comprehensive theory of institutional functioning, many of continuing relevance to the understanding of therapeutic community practice and most, I suggest, remaining to be explored. He expressed this in the form of a matrix, one axis of which specified the structural dimensions of a community (territory/person/time) and the other the functional dimensions (directive v. non-directive/split v. non-split/rigid v. loose), the resulting nine cells of which generated examples drawn from this host of potential investigations. Such theorising is, perhaps, Crocket's major legacy to the therapeutic community movement.

He was energetic in promulgating such ideas both nationally and internationally. On the national scene, he was active in the Psychotherapy Section of the Royal Medico-Psychological Association, being its secretary in 1958–59 and Chairman in 1962–63 (Crocket 1962b), as well as lecturing to a variety of medical societies and conferences. Internationally, he discussed his work in Czechoslovakia, Germany, Holland, the USA (a visit of which a structuralist diary remains) and New Zealand where he spent some months immediately following his retirement. Also, he was a founder member of the Society of Clinical Psychiatrists, an organisation campaigning at that time for clinical autonomy for mental hospital consultants over against the hegemony of the more reactionary Medical Superintendents, which he actively supported in professional publications and the occasional communication to the newspapers (Anon 1972).

Closer to home, liaison consultancy to general hospitals in Oldchurch continued for some years. But, in particular, brief mention should be made of Crocket's work in child psychiatry. As noted in the Ingrebourne Study, among the 454 patients treated in 1957–59 were 58 children (0–15 years) and 30 adolescents (16–19 years). As well as this hospital-based work, there was consultancy to institutions, including a local Community Home with Education in which therapeutic community methods were introduced (Crocket 1962c). This setting provided the model for the leading figure in Peter Shaffer's 'Equus', Crocket himself being the model for the psychiatrist (St Blaize-Molony 2007) – the character who is, in fact, as much a central interest of that play as the young man who blinds the horses.

Nor were his extra-mural interests confined to the clinical field. For example, he took a keen interest in Quakerism, without himself embracing the tenets of that organisation, but attending from time to time the meetings of the local Society of Friends, and he also participated occasionally in Anglican clergy-training events (Crocket 1965a, 1967).

The Round Table and the ATC

One of Crocket's most significant avenues for the dispersal and development of his own ideas was his participation in the Therapeutic Community Round Table and its successor the Association of Therapeutic Communities. The early history of these institutions lies beyond the scope of this paper, but David Clark (1999)

has outlined the progression beginning with an unsuccessful joint conference at Edinburgh in September 1969 of the World Federation of Mental Health and the National Association of Mental Health which stimulated Stuart Whiteley to invite a selected group of senior practitioners to meet at the Henderson in July 1970. This initiated the Therapeutic Community Round Table, the purpose of which was:

> … to gather together people who by their own researches, publications or long experience in this particular field have considerable knowledge to share with colleagues at the same level in the hope that many of the ideological and practical problems with which we are faced can be worked out.
>
> It is quite clearly recognised that at this stage those working at other levels in therapeutic communities, including patients, are excluded.
>
> (Whiteley, quoted by Clark)

This group of 26 members, mainly mental hospital psychiatrists, was to meet every few months visiting the various hospitals represented, the next occasion being hosted by Crocket at the Ingrebourne Centre in the following October. Its agenda was influenced in part by the growing problems of the 'routinization' (Manning 1989) of therapeutic community practice from the earlier, heady days of revolutionary excitement. Crocket was a regular and fully-contributing participant to the substantive discussions of the Round Table, but, characteristically, he was also concerned about its structure. There survives a brief note (Crocket 1971) which starts with the observation that the group had then been meeting long enough for its characterisation and needs to become apparent and its continuance 'may depend upon some formalisation.' The five short paragraphs that follow contain an analysis strikingly similar to the concepts developed at Ingrebourne. The *task* (preserving the informal nature of the transactions) is related to *person* or membership ('If these are to remain on an informal group basis membership has to be restricted'); *time* (a waiting list for membership might be established); issues of *permissiveness or direction* ('if a member misses more than one meeting in 12 months a vacancy might automatically ensue'); and wider *structure* (additional groups for those on the waiting list; a possible federation of groups each with its own characteristics; an annual or biannual conference, etc.). And it concludes with a reflection typical of Crocket that:

> Understandings about these arrangements are themselves open to theoretical discussion – one professional justification for the group's continuation as a structural addition to existing therapeutic community work. (Crocket 1971)

The actual proposals of that little vignette were never acted upon because they were overtaken by the beginnings of another organisation with wider membership, certainly including other mental health professionals (who had protested against the perceived elitism of the Round Table) and, more debatably, patients. A meeting of the Round Table at Halliwick Hospital had generated a small working group where, as the ATC Newsletter records:

> … the seven people who had expressed an interest arranged to meet again to talk about the formation of some kind of Association, the production of a newsletter and the determination of the date and place of the next conference
>
> (ATC Newsletter No. 2 1972)

… and so the Association of Therapeutic Communities was born. Crocket was a life-long member of the ATC and an enthusiastic, if critical, supporter of its work. His name recurs in the minutes and newsletters of the early years of that organisation – most often, as might be expected, in relation to structural questions – and his influence was substantial. But these matters belong more to the general history of the Association. Among Crocket's particular contributions, I select here the Research Group.

The ATC Research Group was established relatively quickly; it first reported in the Newsletter in 1974 when Robert ('Bob') Clemmy of Littlemore Hospital was convenor and the practice of meeting not only at general ATC Conferences but also independently between them had already been established. By the following year, influenced by David Kennard and Nick Manning among others, the group had progressed from talking about research to undertaking small investigations itself and in 1976 it considered a proposal by Richard Crocket to investigate the timetables of member therapeutic communities. The Community Time Structure project that resulted strongly reflected Crocket's approach to the study of structural matters and was the final piece of empirical research with which he was associated. Briefly, the project asked each of the 20 participating communities to provide a record over the same seven-day period in June 1977 of the times formally allocated to a variety of types of group (all patients/all staff; all patients/some staff, etc.) and timetabled individual sessions, and also to provide on a visual analogue scale the extent to which the community believed itself to be 'Like' *versus* 'Not at all like' the therapeutic community as generally understood. The broad result was that the more time a unit spends in meetings in total, or in community meetings, or in subgroups, and the more meetings in total it has, the more strongly will it approach the idea of the 'therapeutic community' (Crocket et al. 1978; see also Manning 1989). This is a relatively robust finding – a small example of the out-working of Crocket's vision of a comprehensive programme of research mapping the structure and function of such institutions.

Before leaving this phase of Crocket's life, it is worth recalling the social context within which he – and, indeed, the whole therapeutic communities' movement – was working at that time. The authoritative historian of the British mental health services, Kathleen Jones, has described the political background dominated by what she calls the Ideologies of Destruction (Jones 1993:Ch.10). It all began with a speech by the then Minister of Health, Enoch Powell, to the annual conference of the NAMH announcing the 'elimination' of the existing '… asylums which our forefathers built with such immense solidity. … isolated, majestic, imperious, brooded over by the gigantic chimney and water-tower combined, rising unmistakeable and daunting out of the countryside …' (Jones 1993:160). The year was 1961, and the intention a radical reconstruction of the

nation's mental health services based upon general hospital inpatient units plus community care – neither, in the event, being adequately researched or resourced. 'Do not underestimate the power of resistance to our assault,' Powell continued. 'Let me describe some of the defences we have to storm' (quoted in Jones:160).

Among those in the therapeutic communities' movement thus defined as part of the 'resistance to assault' that 'we have to storm', Crocket was perhaps relatively protected because the Ingrebourne Centre, although originating as a mental hospital outpost, had as indicated above reached comparative safety under the administrative wing of a general hospital. With few exceptions this was not to be the case for the majority of the 16 institutions represented at the Round Table, and the full story of the disappearance of the therapeutic communities in this period of destruction remains to be recorded.

The Paddington post-script

Crocket's personal experience of this process took place elsewhere. Early in 1977 he resigned his post at Ingrebourne and accepted appointment as locum medical director of the Paddington Day Hospital. The intention was to effect, in essence, a rescue operation in a therapeutic community located within a larger neurosis centre that had fallen into complex difficulties involving serious misapplications of (largely, Ezrelian) psychoanalytic ideas to the regime. These ultimately led to two public enquiries and the suspension and dismissal of the medical director from whom Crocket took over. Although he proposed rational plans to recover this situation, these proved unavailing and he retired, disappointed, on the closure of the unit in 1979.

A sociological study of the events preceding Crocket's arrival at the Paddington Day Hospital was first published by Claire Baron in 1984 appearing at book length in 1987. He had identified himself as the 'clinician responsible in the run up to the second enquiry and during dissolution' in a response to Baron's earlier report (Crocket 1985) where he attempted a retrospective analysis of the earlier events in social network terms which, in turn, were questioned by Baron (1985). That there may still be lessons to be learned from these melancholy and convoluted events is demonstrated by the appearance of a recent reconsideration by Helen Spandler (2006). However, the local management which had become entrenched in negative attitudes towards the institution and the increasingly adverse political climate probably meant it was doomed beyond anyone's best endeavours.

Envoi

On retirement, Crocket went to New Zealand for some months, mainly spent in a locum appointment at Dunedin and returned to live in his carefully redesigned house in Oxford. Here he pursued his wide cultural interests in literature, music and, despite his red/green colour blindness, painting, and maintained steady contact with his beloved Scottish holiday home where – again, typically of the

man – he created a network of like-minded people in a cottage-exchange scheme. But he also continued to think deeply about the constitution and function of therapeutic communities, putting together over a number of years a bulky manuscript on 'The Theory of the Therapeutic Community: An Essay in Space, Time, Love and Hate'.[8] If the word had not acquired its recent pejorative overtones, his unending pursuit of first principles could characterise him as a fundamentalist in his approach to structural psychiatry and the use of Intensive Treatment Networks. This manuscript was subject to many rounds of revision and remains unpublished, although available among his collected papers.

How, then, are we to estimate Richard Crocket as a therapeutic community pioneer? My own judgement is that the construction, largely from first principles, and operation of an exemplary therapeutic community deserves that accolade. But Graeme Farquharson who worked at Ingrebourne between 1981 and 1985 recalls that Richard Crocket:

> … did not 'loom' over the Ingrebourne Community in anything like the way Max [Jones] did at Henderson. I barely remember his name coming up, except from Jeff [Roberts]. Nor was there anything like the 'Old Boys and Girls' network of [the] Henderson.

Indeed, he was never gratuitously self-promoting. However, of much greater and more lasting significance in my view is the breadth and depth of his theoretical thinking. As noted above, his collected papers are deposited at the PETT Archive and Study Centre:[2] they surely remain a valuable resource for future scholars.

His last few years were overtaken by infirmity, to which he responded with clear-sighted self-examination, great honesty and courage. He is survived by his widow, a consultant psychiatrist from whom he had lived separately for many years, and their three children. And the therapeutic community movement takes leave of a major figure in our field.

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Cultural Review

The Transpersonal, Spirituality in Psychotherapy and Counselling 2nd Edition

by John Rowan

Published by Routledge, Taylor & Francis Group (London) 2005
ISBN:1-58391-987-2

The *Transpersonal* is a very attractive paperback that intrigues the reader with compelling bold headings, an enticing use of diagrams and figures, and many of the sections include quotations inspiring you to read more of the author's interested areas. John Rowan's aim is to attract anyone interested in psychotherapy and argues that if we are to acknowledge the *whole* person then spirituality is an important part of this and should be acknowledged. This book is to assist the therapists' creativity and enable the therapist to become a more adaptable therapist, as well as introducing transpersonal therapy as a therapy to act as an addition to other psychotherapies.

The introduction begins by, rather frustratingly, talking about what transpersonal is not, rather than enlightening the reader of what one is trying to understand. Rowan proceeds by explaining how the transpersonal is used in the everyday world and relates this to six different levels of intuition. He includes a brief introduction to some pioneers that have helped influence the field of the transpersonal. He includes: Jung; Assagiolini, who first used the term 'transpersonal'; and Maslow, who included the recognition of self-actualisation, which is an element of the transpersonal.

The author then divides the book up into three parts, 'Being, Doing and Knowing'. The 'Being' in part one of this book describes the different levels of consciousness of state of mind and explores this in some depth.

The 'Doing' in part two of the book reveals what the practitioner does in the practice of the transpersonal. It looks at how the use of imagery and visualisation can be utilised and practised with quotes and clinical examples of the practice. It includes the use of guided fantasy, dream interpretation and dream sharing, on an individual basis and in group sessions. Some sections

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include selected techniques and instructions for visualisation and guided fantasy. Some clinical case stories of examples of dream interpretation are also included, which keeps the reader interested, along with some practical instruction and advice on dream sharing. He continues on a broad horizon covering 'Spiritual emergencies', and how to address situations that were unprepared for in the therapy.

There is a particular chapter aimed at exploring cross-cultural work, as the transpersonal is said to respect religious experiences. Again he uses a transparent clinical dialogue to help the reader understand the issues described. There is a Meditation chapter, which has clear discussion and offers the reader some advice and exercises in the practical application of meditation.

The 'Knowing' part in the final section of the book looks at the issues arising from the theory of the transpersonal. It attempts to answer some of the critiques that arise in this field of the transpersonal.

To conclude, the book offers a thorough introduction to a wide range of issues in the world of the transpersonal, which opens the eyes of the reader to how spirituality can be integrated within the world of psychotherapy. He also has an extensive directory of references and of further reading in the bibliography. With its colourful examples, illustrations, diagrams and instructions it can be utilised to enhance the practice of any practitioner working in psychotherapy.

ATCA's 2008 Annual Conference

"Advancing the Therapeutic Community Approach"

9th, 10th, 11th September 2008

Byron Bay, Australia

ATCA is pleased to announce that the international guest speakers for this year's annual conference are:

Dr George De Leon and Dr Nancy Jainchill

Dr De Leon is the former Director of the Centre of Therapeutic Community Research at the National Development and Research Institutes, New York. Dr De Leon has made significant contributions in the areas of clinical practice and professional education. He provides training in therapeutic community practice for AOD professionals working in treatment programs including correctional settings.

Dr Nancy Jainchill is the current Director of the Center for Therapeutic Community Research at NDRI. Dr Jainchill has been involved with substance abuse research involving therapeutic communities for over 20 years. Her more recent research addresses juvenile justice and issues of reentry from residential settings, correctional and community-based. Her areas of focus include adolescents, gender issues, and co-morbidity.

In addition to plenary sessions, Dr De Leon and Dr Jainchill will also conduct interactive workshops focusing on professional practice in standard and modified TCs and correctional settings.

Other streams programmed for the conference include:

- Co-morbidity
- Family inclusive interventions
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- Diversion, TCs in prisons
- Rural services, access and equity in the bush

For more information about the conference, including registration, conference accommodation and site visits, follow the link:
http://www.atca.com.au/03_conferences/Conference%20Notice3.pdf

Call for Abstracts

The conference program still has a few places available for presentations.
The Call for Abstracts deadline has been extended to 15th July 2008.
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Knowledge development – exploring the obstacles and possibilities

Växjö University, Sweden, 6-8 October 2008

The 11th International Symposium aims to explore the obstacles and possibilities of knowledge development within this field. One aim is to gather both researchers and practitioners within the field of substance abuse treatment in Europe.

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Knowledge development is a question of exploring an area, not just to deliver ready-made answers. A problem today is that there is very much pressure on clear-cut answers as a part of the evidence debate. However, it is necessary to bring evidence in relation to the discussion about what kind of knowledge is needed, when and how. Another important question is how research and practitioners' knowledge can interact and strengthen each other. At the symposium these questions will be discussed; plenary lectures by invited speakers and seminars will be held with relevance to the following three themes.

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Therapeutic Communities were born out of the radical and creative forces that established alternative forms of mental health care, from the 1950s to the present day. Therapeutic environments, influenced by the ideas developed by this movement, exist in psychiatric settings, social work or penal institutions, in community schemes, in projects for the homeless, in the drug and alcohol fields, and in educational and industrial settings. The Journal aims to build upon this creative legacy by stimulating a continual critical rethinking of the possibilities for developing therapeutic and relational potential, within whatever communities readers work and live. It aims to provide a forum in which those engaged in developing, managing and sustaining therapeutic cultures can communicate their experiences, the effects of political and social policy on their own settings, their ideas, developments and findings; and can disseminate good practice and explore what happens when things go wrong.

The Journal publishes academic papers, case studies, empirical research and opinion. The Journal is interested in publishing papers that critically and creatively engage with ideas drawn from a range of discourses: the therapeutic community movement and other related professional practice, psychoanalysis, art, literature, poetry, music, architecture, culture, education, philosophy, religion and environmental studies. It will be of value to those who work in health services, social services, voluntary and charitable organisations, and for all professionals involved with staff teams, service users and experts by experience in therapeutic communities, therapeutic environments and supportive organisations.

General Guidelines

Original contributions that fall within the scope of the Journal are welcomed, including articles on current issues, practice, theory and research (academic papers), case studies of particular communities or organisational environments, and personal contributions arising from the experience of the author. The Editorial Collective uses different criteria to assess contributions in these categories, and the following guidelines are provided. It will assist us in assessing papers if authors indicate which guidelines they have followed.

Final articles for publication should be typed in double spacing and submitted as an email attachment to Lorna Viikna, the Journal Manager (tcj@nottshc.nhs.uk). All articles are submitted for peer review by anonymised assessors drawn from the Editorial Collective, the International Editorial Advisory Group, and a panel of assessors. Authors will receive acknowledgement of their submissions.

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The editorial collective aim to ensure that all articles published in the Therapeutic Communities Journal report on work that is morally acceptable. To this end, the Journal will appraise the ethical aspects of any submitted work that involves human participants and will ensure that authors obtain informed consent from any participants included in their research.

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These can include reports of original research, papers developing original links between theory and practice, review articles and critiques of current practice. The normal conventions of academic papers should be observed, with a brief abstract (up to 150 words), followed by a review of the relevant literature, statement of the problem, method, findings, discussion and conclusion. References should follow the style of the Journal. Academic papers should normally not exceed 5,000 words excluding references.

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These describe examples of practice, innovation, action research or evaluation in the practitioner's own unit. They should include: a brief description of the setting, of the piece of work undertaken and the reasons for doing it; a clear account of the process and findings with relevant data in easy to read tables or graphics; a brief conclusion with discussion of the findings and their implications for practice within the unit and perhaps more widely. A small number of relevant references may be included, following the style of the Journal, but no literature review is needed. Case studies should normally not exceed 2,500 words.

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The Journal would welcome short papers (up to 2,000 words), which address topical issues. These issues may arise from recent themes or views addressed within the papers in the Journal, from within therapeutic communities, they may emanate from strategic developments within the Association of Therapeutic Communities (for example the issues of accreditation of communities and training), or be generated by national and international policy initiatives, that have an effect on therapeutic practice, the way in which it is thought about or conducted. We are seeking relevant commentaries, which are reflective and thoughtful, yet critical and perhaps at times controversial; and views and opinions which will stimulate debate, provoke thoughtfulness and hopefully new ideas, with which to approach contemporary issues.

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Readers are invited to send in personal accounts of some aspect of their work that may be of interest to others. The intention of such contributions is to share experience and problems, raise questions and encourage discussion. These may describe an event or situation involving the writer, occurring at the individual, group or organisational level. Contributions from experienced practitioners as well as novices are welcomed. The account should begin with a brief description of the setting, participants and background, followed by details of the particular event or situation and, if appropriate, the responses of the writer and others involved. No literature review, theoretical exposition or references are needed. Confidentiality should be maintained by disguising the identities of individuals or organisations, and authors may request that contributions are published without attribution. Personal contributions should normally be limited to 1,500 words. With the author's permission comments may be sought from practitioners with relevant experience to appear alongside personal contributions.

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