

ESTABLISHING A BALINT GROUP FOR MENTAL HEALTH WORKERS – THE INALA COMMUNITY MENTAL HEALTH EXPERIENCE

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ABSTRACT: The paper describes the context in which a new Balint group for mental health workers arises in a suburban Australian community clinic, the process of the formation of the group and the evolution of the first five group meetings. The author expresses his hope that the group might serve to ameliorate the tendency to demoralization of mental health workers engaging with their clients in a setting of socioeconomic disadvantage and cultural diversity

Inala Community Mental Health services a population of approximately 200 000 people in the southwest of Brisbane, a subtropical east coast Australian city of 1.75 million people, most of whom live in detached timber or brick houses in suburbs that sprawl out on either side of a wide meandering river that opens on to Morton Bay, separated from the Pacific Ocean by the world's largest sand islands. Inala, prior to settlement by ten pound British immigrants in the 1960s, had a substantial indigenous population. From that time, the name of the suburb, which was isolated in a semirural setting some 25km from the CBD, with poor access to public transport, came to be despised and associated with social disadvantage. Since the 1960s, successive waves of immigrants have settled there in low cost housing, and a community of pensioners and unemployed people have come to populate the public housing projects and privately owned caravan parks that have proliferated in the area. The largest buildings are a shopping complex known as Inala Civic Centre, Centrelink (the Australian government's social welfare agency) and the Inala Community Health Centre, the ground floor of which is shared by the Community Mental Health Service, the Indigenous Health Service and the Alcohol, Tobacco and Other Drugs Service. Upstairs is the University of Queensland School of Medicine's general practice clinic, established in the 1970s by the Whitlam Labor government as a research centre for socialised family medicine. Other legacies that reformist government gifted to the

Australian people included free tertiary education and universal health insurance, gradually eroded by subsequent governments into generously subsidised user-pays systems. The reforms still prevailed when I entered medical school, and contributed to the culture of hope and generosity within which I was taught primary care medicine as an undergraduate at the Inala Community Health Centre. While Balint groups were not a part of our undergraduate program, Michael Balint's emphasis on psychological medicine and the doctor-patient relationship were taught and practised, and The Doctor, His Patient and the Illness and The Fifteen Minute Hour were textbooks supporting our curriculum.

Twenty-four years after completing my undergraduate final rotation in Community Practice, and after 16 years in private practice as a consultant psychiatrist and psychotherapist with post-graduate trainings in psychiatry, psychoanalytic psychotherapy and creative writing, I returned to public sector practice in order to increase my involvement in teaching and training, obtaining a permanent appointment as Senior Staff Specialist at Inala Community Mental Health. I found that in spite of those waves of poor migrants, Inala remained a long way from the ocean; that Michael Balint had been forgotten; that the second hand clothing shops at the Civic Centre had been replaced by rows of Vietnamese greengrocers; that one of the many forensic patients in my outpatient practice had attempted to burn down Centrelink and the Civic Centre; that the only place to park my car was at the roadside next to the park in which a young woman had been recently murdered and from which a drug-crazed man wielding a samurai sword had been taken to the hospital to which my patients are admitted; and that patients discharged from other services were prone to attend demanding attention by drawing their machetes. I found myself working with a team of idealistic mental health workers bearing the appellation of 'case managers' - nurses, psychologists, social workers and occupational therapists, struggling to sustain hope in their capacity to benefit their clients in spite of their heavy caseloads, but mostly espousing devotion to a highly medicalised model of intervention. When I was not involved in direct clinical assessments, which were always performed jointly with the case managers, I found them to be hungry for support and advice, especially that which facilitated psychological insight into their clients' problems, and that which left room for explanations of the failure of medical treatment other than for the wrong psychiatric diagnosis,

medication dose reductions, the patients' perversity or the case managers' incompetence. Initially I found myself derided, deskilled and regarded with suspicion as though I either must be joining them because I was too gormless to make a go of private practice, or else I might be sent there as the sinister agent-messenger of the corporate Big Other. In spite of this, I found myself constantly mobbed for advice, with consultations often sought in the corridors and tremendous pressure exerted to provide solutions without prior knowledge and outside of the context of the careful development of a therapeutic alliance. One day I found myself hunting for a patient file at the back of a large compactus in the administration area. Two of the case managers blocked the exit and simultaneously began their agitated narrations of their clients' woeful situations. I had a panic attack. In its aftermath, and that of my first Balint group leadership training workshop, I resolved to offer the case managers the opportunity to receive a kind of supportive intervention very different to that which they were accustomed - the possibility of receiving regular peer supervision and support focussed on consideration of the direct experience of the clinician-client relationship in the context of Balint group.

I broached the idea with our team leader, a nurse manager with extensive prior experience as a clinician in emergency psychiatry, a woman whom I had observed to have considerable capacity for emotional containment, and for approaching stressful situations in a calm and thoughtful manner. She was curious to know what the leadership workshop that I had recently attended might be about, and listened attentively to my explanation of the Balint group process and its historical relationship to the ideology that had sustained the Inala Community Health Service in its earlier years. She agreed that I should offer the possibility of forming a Balint group to the case managers at our next team meeting, and responded positively to my request that she join me as a co-leader for the group, initially by time keeping and debriefing with me after each session. I suggested that I would welcome her more active support and intervention as she gradually became accustomed to the process. At the team meeting, there was considerable interest in the idea, and six or so of the case managers expressed their intention to join the group, with a few others expressing ambivalence. One raised the potential problems arising out of clinicians with different trainings and expertise, and potentially antagonistic

ideologies attempting to join in supervision as peers. Others seemed to view the plan as potentially subversive of existing vertical hierarchies within the corporate culture of the health service. I could say nothing to allay this latter anxiety.

I suggested that we should meet fortnightly for an hour-long presentation and discussion of a single case, focussing on the psychological aspects of the case, especially on the case manager-client relationship. The first three meetings were arranged to immediately follow the team meeting on Wednesday mornings, in a timeslot usually set aside for staff development and training. The first meeting was well attended, but there was a long silence before one of the participants offered to present a case. In this meeting and the next, I noticed reluctance on the part of the presenters to talk about their own feelings, with some cautious testing of the consequences of expressions of frustration related to disempowerment. I attempted interventions that encouraged imaginative discussion of the feelings and thoughts of those the case managers believed were powerful in relation to them and their clients, usually the senior medical staff, among whom I was numbered. I found some of the defensive responses painful, including those to the effect that whatever our clinical director might have to say about the situation, it would be right. The case manager's fear of saying something that might be construed as subversive or disrespectful awakened in me wishes to transgress in just such a fashion, wishes that I attempted to consciously acknowledge but to refrain from overtly enacting. There were moments when I had to remind myself of the potential benefits of neutrality and restraint in leadership, traits that I admired in my coleader, new as she was to the Balint process.

The third Balint group meeting fell outside of the intended fortnightly sequence, due to me being required to participate in a corporate orientation process that followed my appointment to permanence. Only one of the case managers attended. The team leader and I offered her a joint supervision of the case that was troubling her. It is impossible to conduct a Balint group with only one participant. I found this experience quite demoralising, but after debriefing with my coleader, I raised the issue again at the team meeting, where most of the case managers expressed their continuing interest, but raised various concerns about the timing of the meetings, and their difficulties attending when pressed by other

commitments. I empathised with these difficulties, and announced the need for a change in the timeslot for the group, as much due to changes in my schedule as due to the problems with theirs. We settled on an early Tuesday morning time as the alternative and agreed to meet fortnightly. My clinical director, although he was not familiar with the Balint process, supported it by publicly announcing to the team that the Balint group was to be considered a compulsory part of the professional development program. I had previously emphasised the voluntary nature of the commitment, but I appreciated this expression of support, and I was relieved to find that the first meeting at the new time was well attended, and that the presenter, a nurse in his thirties whom I had noticed as having a capacity for calm and sound clinical judgement in emergencies, began his presentation by acknowledging his feelings of demoralisation and frustration in relation to the patient whose care he was discussing, a 22 year old man born in New Zealand (from whence one in six residents of Brisbane have originated) to Polynesian parents who had migrated there from Pacific Islands further to the north. The presenter told us that he had been called to advise and assist the previous day after the patient's parents had called the police to pick up their son from the park where he had spent the morning lying out in the sun sniffing petrol, across the road from the family home, within eyeshot of his mother, who became too distressed to be able to bear to watch him any longer. The patient had a four year history of schizophrenia in which the onset of positive symptoms including command hallucinations, disorganised thinking and behaviour had followed a period of gradual deterioration involving increased impulsivity, massive weight gain, lethargy and torpidude, punctuated by outbreaks of petty crime and the progressively relentless abuse of psychoactive substances including alcohol, cannabis, amphetamines and inhalants. The patient had no interest in his case manager's efforts to involve him in social and rehabilitative groups and to refer him to the drug and alcohol service. When the patient had been hospitalised, his condition had considerably improved with antipsychotic medication and enforced abstinence from substance abuse, but he rapidly relapsed each time he was discharged from hospital, in spite of his compliance with medication being ensured by fortnightly depot intramuscular injections. When asked by another member of the group about what he thought motivated the patient's petrol sniffing, the case manager responded that he thought that it was the pursuit of pleasure to the exclusion of all other goals, that his

patient seemed oblivious to the mental anguish that his actions caused his mother, the impotent rage that they aroused in his father and the feelings of frustration, helplessness and futility experienced by his case manager. After the presenter told the group about the case and a period of factual questions from the group followed, I invited him to push back and observe the process in silence until invited to rejoin the group for the last ten minutes. The patients we work with are a culturally diverse group, as are the clinicians who make up our team. Case managers of indigenous Australian, Chinese, Vietnamese, Persian, and Anglo-Celtic Australian backgrounds have participated in the Inala Balint group, including several for whom English is a second language. Sensitivity to cultural difference is one of the team's strengths. The discussion did not go far before the issue of the difficulty of making a culturally attuned response to the problems the patient presented to his family, his case manager were raised, as was the marginal position he had taken up with respect to the community within which he lived. A lot of sympathy was expressed for the patient's mother, and the cultural meaning of eating and growing big was speculated upon. The intervention I offered in response to this was to ask the group to imagine what the patient's father might want to say to the group about the problem. When the case manager rejoined the group, he was able to express more of his frustration and demoralisation, and to put words to his sense of being entirely at a loss as to how intervene helpfully.

After the group, I had half an hour to debrief with the team leader and address other administrative issues before seeing my first patient for the day – the patient who had been presented to the group and whom I was meeting for the first time today, jointly with his case manager, for the purpose of making an assessment and preparing a report regarding the relationship of his illness to his recent offending by driving without a license. Two days later the case manager approached me and told me about the fresh approach he had taken in dealing with the patient's family – asking them how the patient's problem would have been dealt with had it arisen in a traditional village setting on the island they had come from. This resulted in a family decision to take the patient back to that island for a holiday and seek the advice and assistance of community elders.

Between the fourth and the fifth meetings of our new Balint group, a malfunction in the air condition caused water to leak into the ceiling of our

clinic, which collapsed into one of our consulting rooms. Somehow the emergency repairs were negotiated without the presentation of a formal business case, in spite of Christmas coming. At the fifth meeting today, I noticed that the presenter launched readily into talking about how he had been touched emotionally by the response of a schizophrenic patient with a history of violent sexual offences when the case manager had passed on to the patient a Christmas gift donated by a charitable organisation. A discussion of the emotional difficulties case managers encountered in dealing with the many patients we manage who have a history of violent offending. When I began my clinic after the group this morning, I found that once again my first patient was the one chosen for discussion in the group, and the presenter and I were working together with the patient as a treating team, both of us having to negotiate a rapid switch in roles. The possibility occurs to me that a pattern is emerging, but two fish do not constitute a school, and I will endeavour to keep my mind open to the possibility of something different all together coming out of our next Balint group meeting, trusting that while the ceiling of the clinic may cave in, the sky will not fall on us. We will continue with our work, and not be crushed.