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Making Good of Crisis: Temporalities of Care in UK Mental Health Services

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ABSTRACT

A paradoxical concept of crisis has come to dominate contemporary understandings of suffering and care: as that which will reach a critical turning point, while also being chronic and enduring. I analyze this temporal enigma through an ethnography of mental health care practitioners in the UK who see themselves as embedded in a crisis-stricken care system, yet attempt to reformulate their therapeutic approach to crisis in productive ways: to make "good" of crisis. I argue that their efforts to make good in and of the temporal interstices of crisis disclose care as temporally unstable as well as ethically ambivalent.

KEYWORDS

UK; care; crisis; temporality; ethics; mental health

In the midst of the UK's experience of the coronavirus pandemic in September 2020, an opposition politician was widely chastised for suggesting that her fellow Labor party members should not 'let a good crisis go to waste.'[1] Social and print media rounded on the shadow education secretary, Kate Green, with arguments that her attempt to make party political advances in response to the pandemic was offensive because it would undermine a less partisan response to human suffering. In Green's apology for her comment, she explained that her meaning was that "the crisis has exposed all sorts of things about our economy and about the pressure on our public services that we've got to learn from, we have to learn the lessons of this pandemic."[2] The invitation not to let a good crisis go to waste was an echo of earlier political actors' rumored deployment of the same phrase, which – despite the public anger at its use in this context – taps into a dominant and widely mobilized understanding of the idea of "crisis." As a moment of acute suffering, crisis is understood in scholarly and popular contexts as an opportunity for transformation, a moment which reveals a truth about why things cannot remain as they are. In this article, I bring ethnographic material from the UK's chronically "crisis-stricken" mental health-care system into dialogue with critical perspectives on crisis temporalities, in an analysis of the ethically unstable nature of care. I advance this conversation by concentrating on the question raised by Green's statement, that of what makes a "good crisis"? For it was the implication that there is an ethically "good" quality to the experience of acute suffering that provoked condemnations of her words, and yet people constantly seek meaning, consolation, and redemptive potential in the narration and experience of crisis. Similarly, the simultaneously difficult and reparative experiences of "crisis" of the mental health-care practitioners with whom I conducted research invite us to sit with the notion's temporal and political paradoxes.

To understand how people make ethical meaning and affective connection in the midst of crisis, we must unfold the temporal modes hidden in the rush to overcome and move beyond its acute phase. Zoe Wool and Julie Livingston take up this task as they question the assumption of a redemptive or progressive telos in crisis narratives (Wool and Livingston 2017). They propose,

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Media teaser: UK mental health care workers navigate contradictory ideas and times of crisis, as they attempt to provide good care in the context of austerity.

instead, the concept of "collateral afterworlds" to describe toxic or precarious circumstances that persist, and that are neither meaningless nor transformative. An ethnographic sensibility toward experiences of what is commonly described as crisis may, they write, "slow the rush to transform endurance into transcendence" (7), which they argue is a habit of both scholarly work and liberal-progressive political thought. This highlights how crisis narratives, though often intended to manifest and bolster forms of hope, are also complicit with "cruel" (Berlant 2011) myths of social repair that depend on people's affective investments and forms of labor that contribute to the perpetuation of the world much as it was before (Wool 2017). Roitman (2013) has noted how the idea of crisis has become saturated in a redemptive teleology of this kind. As she describes, the Greek term "krino" denotes the requirement for judgment or decision, and was rendered within the Hippocratic School as the turning point of a disease, a critical phase in which life or death was at stake. The idea of crisis as a turning point has endured and been further transformed to dominate modern conceptualizations of history as crisis – as itself a temporality upon which one can act, and in which critique and thus change are possible. Roitman's analysis also points to the paradox of the contemporary shift from crisis as turning point, however, toward the idea of crisis as an enduring condition. That is, although crisis signifies a critical, decisive moment – one which reveals the truth of a situation and can generate transformation – it has also lost its transient temporality, as the life and death phase of the disease has come to be normalized as chronic and enduring. Hence, not only does a critical perspective on crisis need to grapple with its salvific ethos, as Wool and Livingston (2017) argue, but it also finds this conceptualization of progressive change to be dominant even when crisis perpetually fails to come to an end. A consideration of the ethics of care in crisis must begin, then, by reckoning with the temporal knot at its heart.

Engaging with normative representations of crisis as chronic and enduring, which also hold cruel promises of salvation, scholars focusing on various ethnographic articulations of crisis have identified the concept as "a counterrevolutionary force in the twenty-first century, a call to confront collective endangerment that instead increasingly articulates the very limits of the political" (Masco 2017:s67). In relation to the "climate crisis" (Masco 2017), the "refugee crisis" (Cabot 2016b; De Genova and Tazzioli 2016; Giordano 2020), and the "financial crisis" (Roitman 2013), these authors demonstrate a need to resist crisis talk that mobilizes fear about a disintegrating social in order to reinforce conservative governance, in the process dampening potential for revolutionary affects and ethical commitments that denaturalize the political status quo (Masco 2017; cf. Anderson 2016). Equally, a focus on crisis "hot spots," when scholars, activists, and politicians alike turn their attention to recently emergent, and thus exotic and appealing, sites of suffering obscures the slow, banal, unheroic history of a "crisis yet to come" (Cabot 2016a). Crisis as explanation exploits a form of publicity that sensationalizes and defers the unknowability of the social and the psychological (Davis 2015). As I explore my interlocutors' efforts to endure the slower, unsettling temporalities of crisis, while also finding ethical meaning and reparative affects within it, I therefore follow those who seek to attend to how "the internal phenomenology of the crisis is bound up with [people's] method for relating to crisis, for judging it, for living with it." As Knight and Stewart write (2016:11), "the ethnographic study of crises must thus proceed empirically to capture the actual decisions or non-decisions that people make, the actual temporal processes by which they judge responses, if and when they manage to do that." In order to do that, I argue, we must ethnographically unpick the coexisting temporalities that are obscured in an overarching crisis narrative, tracing how processes of endurance or transformation manifest in our interlocutors' navigation of this temporal instability. In this article, I do this in an engagement with mental health practitioners in England practicing a novel therapeutic method as a way to care in, and through, crisis.

"Sitting with" crisis

UK-based mental health care practitioners with whom I conducted research engage a therapeutic approach called Peer-Supported Open Dialogue ("POD"), largely in response to their sense that mental health care services for people "in crisis" are often deficient in providing meaningful care. My interlocutors describe a "sticking plaster" approach whereby immediate material problems (housing, money) are minimally addressed to keep people just about afloat, and symptoms of psychological suffering are treated with medications (sometimes involuntarily) to dampen the risk of imminent physical harm. There is little time written into the system of care provision for any kind of talking therapy, and what there is – usually Cognitive Behavioral Therapy, usually months down the line – is often insufficient in keeping people "well." These care workers (nurses, social workers, psychologists, psychiatrists, occupational therapists, peer workers) voice their concerns as part of a wider narrative about mental health care services in the UK as being in chronic crisis. Even beyond those intimately familiar with the shape of these services, a lack of resources within NHS mental health care is routinely described as being "in crisis" in the media and in everyday conversations. This follows deinstitutionalization and the heralding of "community care," but also budget cuts across mental health care services, particularly since 2010 as austerity measures were brought in by the Conservative government as a response to the "financial crisis." The condition of being chronically short of resources is felt at the everyday level of these practitioners' working lives as putting immense pressure on their time, their skills, and their boundaries.

POD is presented by its advocates as a way to transform the care offered to those facing acute psychological distress, primarily by changing the form of care offered to someone "in crisis." Rather than rushing to move beyond the crisis – "shutting it down," as these practitioners suggest – the practice of "sitting with" the pain of others is encouraged, slowing down the pace of response in order to engage more fully with the person's experience of distress. Those training in POD learn a set of linguistic, affective, and temporal techniques intended to transform the nature of the therapeutic encounter they facilitate. In POD, several practitioners will meet with a service user and members of their "social network" (this can refer to anyone the service user wants to bring to a session, but generally – in discussions and in practice – means members of their family). This meeting happens in the midst of crisis, often with people experiencing psychotic symptoms, and practitioners will attempt to create an encounter in which diagnostic categories and questions about medication are secondary to the words and feelings of the service user, their family members and friends, and on the affective responses of the practitioners. In this way, POD proponents suggest, the emotional and relational energy of the crisis can be mobilized to enable people whose voices are otherwise not heard – both within their social and familial contexts and within mental health care services – to guide any treatment plans that may emerge from such sessions. The approach also seeks to avoid, as far as possible, the violence of involuntary hospital admissions and coercive treatment that are otherwise so common in service users' trajectories through mental health care. It is precisely in times of crisis, when experiences of distress are so acute, that the ways in which people relate to and within their social networks have the potential to change, for thoughts and feelings to be expressed that before and after crisis may be stifled, these practitioners propose. POD practitioners thus partake in the notion of crisis as turning point, when service users and the people around them may be enabled, through the facilitation of the flow of their words and expressions, to move toward healing and to witness an improvement of their pre-crisis condition.

Crisis as turning point, in this community of care professionals, however, is also conceptualized by reference to practices of slowing down, pausing, enduring. POD practitioners attempt to reconfigure their own affective states as well as their professional relationships with colleagues, through a set of techniques, including "self-work" as well as group supervision meetings, that aim to suspend the fast-paced and reactive response to crises that tend to characterize their working days. Mindfulness meditation, sharing and reflecting on each other's emotional responses to service users' situations, and attempts to counter the hierarchical nature of professional relationships within their field, are

presented alongside the longer, slower therapeutic sessions with people in the midst of psychological distress, as central to enabling care to take the form of "sitting with" rather than "doing to." In other words, POD practitioners also understand their endeavors, at least in part, as refusing the perpetuation of crisis as enduring and chronic, and the way this is driven by the rush and urgency of crisis as turning point. By offering more time (Baraitser and Brook 2020) in the midst of crisis, they suggest that care may have the effect of opening futures that are not inevitably those of settling back in to the "slow violence" (Nixon 2013) of enduring crisis. Here I outline how they try to do this, and how those efforts remain caught up in differing crisis temporalities. This is an attempt to add to our understandings of what it feels like to engage ethically with crisis, to "not let a good crisis go to waste." For in their attempts to remake crisis as a time of care, rather than deferral or abandonment, POD practitioners are reformulating the ethical potential of crisis, trying to resist dominant temporalities and moralities of crisis as redemptive while also basing their endeavors upon another version of this salvific ethos. In this ethnographic reflection on the paradoxical nature of this project, I suggest that our critical engagements with crisis must attend to people's investments in the coexisting and sometimes contradictory horizons of its temporal modes.

Times of crisis

Peer-Supported Open Dialogue is an intervention into psychological crisis currently being piloted in several NHS trusts in England, with a large-scale Randomized Controlled Trial having begun in July 2018. The approach is a development of Open Dialogue – a therapeutic method developed in Finland's Western Lapland region since the 1980s (Seikkula and Arnkil 2006, 2014) – and follows its core principles and practices.[3] My research with practitioners training in POD and with three community mental health teams practicing the method in one area in southern England follows their endeavors, which they propose have the potential to drastically improve the lives of service users and their families. In this sense POD is one of the most recent incarnations of a decades-long tradition of questioning and challenging mainstream psychiatric practice from within the mental health community through the promotion of alternative therapeutic approaches. However, this approach has, unlike many of these critical practices, recently gained interest and support from key institutional actors such as the Royal College of Psychiatry. In 2017, a group of POD's central advocates in the UK were successful with their application for £2.4million grant funding to run a large-scale five-year research project, including a Randomized Controlled Trial, from the National Institute of Health Research – the primary governmental body in the UK which funds health research in the paradigm of evidence-based medicine. This institutional support is pinned on how POD is represented, not only as having therapeutic effects for individuals, but as attempting to turn around the enduring condition of crisis in mental health care services in the UK. By facilitating healing and reducing the amount of time and number of occasions on which service users will engage acute psychiatric care, the approach is described as potentially highly "cost-effective" and thus valuable in the governmental terms dominant within UK health care. The focus of much discussion about POD, both within the community of its practitioners, and in promotional events and texts, is therefore the systemic and institutional practices that need to change, alongside therapeutic methods used in sessions with networks. While this encompasses funding and research priorities, relationships with NHS trust management figures, Clinical Commissioning Groups,[4] and politicians, the mental health care team has come to be the site through which systemic reform is deemed by POD practitioners, ultimately, to be made possible.

My research began with participant observation in the 2017 national training programme in POD, which led into ethnographic research with three teams who went on to practice POD in one NHS trust in England. Most of those taking the training had years of professional experience working in mental health care, but a small number were those who had recently started working in mental health care or were getting involved as peer support workers, having encountered mental health care services as service users previously. Thus, POD was open to those with different knowledge and experience, and not aimed at any single discipline within mental health care. I wrote extensive field notes on the

training program, and maintained contact with some of the trainees between the residential weeks through interviews. In my work with the three teams, I attended weekly staff meetings, additional training and "self-work" sessions, and interviewed staff members. Alongside these core research activities, I attended events such as conferences and training days, as well as following POD's presence in the mental health community on social media. In what follows, I turn my attention to a team supervision meeting-redescribed as "intervision" to signal its nonhierarchical aspirations – in which crisis is encountered, experienced, and constituted by my interlocutors' words and actions. There we see how the dual temporality of crisis as both chronic and transient is constituted in the relationships, affects, and ethics of the POD practitioners' everyday working worlds.

Intervision "gone live"

Six women and I are sitting cramped round a table in a small room to the side of the large open-plan office space used by this team and other mental health practitioners working in the area of the south-east of England where we are gathered. One of the group, Mandy, has brought some cheesecake along to the meeting, and we pass plates around as the team leader, Jennifer, attempts to get the weekly intervision session underway by asking who has cases they wish to reflect on. Faith, a diminutive and sensitive woman who works as a nurse in the team, starts to talk about a service user she is struggling with, expressing her frustration and anxieties. Jennifer adds Faith's case to the list for discussion, and asks Faith to pause for a few minutes for the group to do their regular mindfulness practice at the start of the meeting, before they start discussing the "content" of what is on team members' minds. A brief exchange between Mandy and Jennifer results in us doing three minutes of silent mindfulness practice (Jennifer suggested five minutes while Mandy was worried about the length of the meeting, given an appointment she had later that morning, and wanted only to do one minute), the shrill tone of the alarm on Jennifer's phone alerting us when we needed to bring our minds "back into the room," and proceed with the business of the day.

Faith was then invited to talk about the case she had mentioned, and she started to tell us about Nadeem, a service user in his early 20s for whom she had been the "care coordinator" for some time, and who had been doing well until a couple of weeks previously, when his mother became concerned that he had stopped taking his regular medications. Nadeem was upset, Faith explained, that the medication caused him to gain weight, as a large man who was conscious about his size and who had received some negative comments about it from acquaintances. He had become more verbally aggressive, and his mother was worried about leaving him alone in their home with his younger sister, and had been calling Faith frequently during the last few days and asking her to come to see them. Sounding exasperated and quite anxious, Faith explained to us that she was confused by the sudden turn in Nadeem's condition, and also worried about making a home visit herself: "she wants me to go there, alone, his mum . . . me, as a small woman, to see this big guy. She's worried about her and her daughter, and I'm worried too. I can't go alone." Rashida, another nurse in the team reflected on what Faith had expressed to us, saying that it sounded like a confusing situation and that Faith felt disoriented by the sudden change in her encounter with Nadeem. Audrey, a psychiatrist, spoke about her own feelings of anxiety on listening to Faith and her worry about the sense that she was alone, and that there was nobody, and no doctor, specifically, to go with her for a home visit: "Because I'm here, and I am a doctor, and I can go with you to see him later today. It sounds like he needs to be seen."

These gestures of reassurance offered by her colleagues, which seemed to be trying to communicate that they had heard her situation, and were seeking to find ways to help her address it, appeared to bother Faith, who kept talking about how recently she had seen him, when he had seemed relatively well, while also looking frequently at her phone. After a few minutes she said she needed to take the call from Nadeem's mother, who kept ringing her, and she did so while in the room with the rest of us, vaguely listening to her end of the conversation while also chatting among each other and continuing to eat cheesecake and drink tea. After the call, Faith told us that Nadeem's mother had reported that he'd left home that morning quite distressed, taking with

him a cricket bat that she was worried he intended to use as a weapon. She had asked Faith to call the police, having left the house herself to go to work and telling her younger daughter to stay away from home. Carefully and somberly, the team discussed what Faith should do. Mandy worried about the implications of calling the police for Nadeem, when we did not know his intentions in having taken the cricket bat, and were not clear why the mother would not contact the police herself, instead asking Faith to do so. Faith sighed and looked pained, telling us how the mother had often made her feel uncomfortable in positioning Faith as "the bad cop," and she felt manipulated on this occasion too. If she were to call the police, how would Nadeem relate to her afterward, when the mother would surely tell him that it was Faith who had reported him? With a look of grave concern on her face, Audrey said she felt it was their duty to notify the police, having been told about the "weapon," and she was worried and anxious about waiting any longer to do so. Perhaps he took the cricket bat to defend himself against the people he felt were bullying him and did not mean to attack anyone unprovoked, Rashida, who had also previously worked with Nadeem, responded. "We know what the police will make of this if they are told there's a big Asian guy wandering around with what is being described as a 'weapon,' and we know that doesn't square with Nadeem – he's a cuddly giant, he's not a violent person." She suggested being careful with language if Faith did report it, stressing that she is concerned about Nadeem's safety as he is in distress and thinks people are seeking to attack him. If the police simply log that he went out in anger with a "weapon," and later pick him up in connection to that, that could have a major impact on his life now and in the future, Rashida noted.

About half an hour into the meeting, another nurse, Julia, bustled into the room, apologizing for her lateness and taking off her coat and bag while pulling up a chair to join the others. She chirpily explained she had been delayed by a service user who was "having a crisis," but that she had managed to resolve things for them for now. As she took her seat and listened as the discussion about Nadeem continued, her tone shifted, and she interjected: "I obviously missed something and sorry if I've not got all the information or you've discussed this already but I think we need to see him, we need to respond. Maybe it's just because I'm quite an anxious person and I'm sorry I'm anxious but I feel time . . . time passing and I think we need to respond." After further discussion, Faith did contact the police, following Rashida's suggestion to word her report carefully, being clear that she had only been told about, but did not have confirmation of, Nadeem carrying a weapon. When she did so, she learned that he had already been picked up by the police, but it was not clear whether he had been arrested, or detained under section 136 of the Mental Health Act, whereby someone can be "taken to a place of safety" if the police are concerned about their wellbeing and the risk they pose to themselves or others. Again, Julia expressed that she felt an urgency to the situation, and that it would be wise for Faith to contact the police again, as soon as possible, and give them information about his condition and history, so that he could get the care he needed and to try to prevent a more punitive outcome. She talked about Faith being an "advocate" for Nadeem, though Faith remained quiet and seemed reticent to make another call. Ultimately, however, she did leave the meeting room to do so, after speaking again with Nadeem's mother, and the rest of team voiced concern for Faith while she was out of the room. They paused this conversation after a few minutes, deciding that it would be better to discuss what had happened and her stress about the situation with Faith present, and Jennifer suggested we close the meeting with some more mindfulness. "It feels like we need it," Julia said. We sat for three minutes, in silent reflection, letting the weight of what Audrey described as "intervision gone live" settle, before gathering our belongings and leaving the room to each go about the rest of the day with separate schedules.

Times of care

The scene I describe here is not an ideal typical example of how POD should proceed; rather, it is a messier instance of how mental health care practitioners tried to change their mode of working in line with POD's approach, while still operating within a system of care geared around the different

temporal forms that are contained within "crisis." It is typical, though, of how those efforts at shifting their care practices played out in the encounter with the dynamics of professional relationships, their responsibilities to both their institutional context and to the service users under their care, and broader socioeconomic and legal infrastructures that are themselves tied up with forms of distinction and inequality along lines of gender, class and race. The affective and temporal modes interacting here navigate and reflect these social and institutional dynamics, such that care in crisis becomes visible as a complex constellation of such encounters. To illustrate this, here I will reflect on how crisis manifests and finds response in the temporalities of this scene.

Convivial time

As with most POD events and meetings I attended, the intervision scene similarly commences with a period of settling in, with colleagues who are also friends catching up, checking in, and establishing a convivial atmosphere, often through commensality. The POD team as a space of care, not only for service users, but for fellow team members, was often reinforced by acts of sharing food, as in this case for no particular reason, or to mark someone's departure for another job or a special occasion such as a birthday, and occasionally as the main event when the team took time out for a "self-work day" or an away day. Such acts, taken for granted here as in many British workplaces, establish the workplace as one involving relationships that go beyond detached professionalism, and enter a more intimate space of friendship and mutual support. In POD, particularly, taking time to respect these relationships was seen as an integral part of the work, as care for fellow team member's emotional states was not only seen as part of being a decent colleague, but as enabling trust, respect, and solidarity to transform how team members would relate to one another in a therapeutic session. In this sense, the fact that meetings were often delayed or overran because participants were having personal conversations, although it sometimes felt like an infringement on professional time, was important for the possibility of a team enduring over time.

Short on time

Mandy's concern about not taking too long for mindfulness, Julia's late arrival to the meeting, and Faith's feeling of being left alone with a difficult case, all relate to a pervasive sense of being short of temporal resources that these mental health care workers often report. There is never enough time, they note, for everything that needs to be done. There are also never enough people to go round: home visits that should involve at least two professionals are either delayed or someone makes the visit alone; the senior member of the team – the consultant psychiatrist – is often absent because of managerial or clinical duties; the number of cases they can discuss in meetings is limited, because everybody has a long list of tasks they need to accomplish outside of the meeting. This feeling of time being in short supply was a major part of what it meant to be in enduring crisis, a state that was as much about not having enough time as it was about the amount of suffering being confronted. Talk of being overwhelmed with a caseload (discussed in terms of numbers of service users for whom any given "care coordinator" was responsible), being tired, fed up, or burned out, was common. Time being short both hindered but also underlined the very need for the above-mentioned convivial time, as taking time out of an already packed schedule for acts of friendship was deemed both difficult and essential.

Pause

An effort to slow things down was a key part of POD's intervention in the therapeutic landscape of NHS mental health care. Against what was perceived as the rush to get people in and out of acute psychiatric care, to medicate using antipsychotic and sedative drugs, to "shut down" the distress of others, POD practitioners were encouraged to "sit with" difficult feelings and to take time to listen before acting. The practice of mindfulness among practitioners (rather than as a therapeutic technique

for clinical work with service users) was one of the main ways in which the urgency of crisis time could be paused. In the POD training, mindfulness sessions, and discussions about them, were dedicated a forty-five-minute slot on each of the five days of the residential course. Trainees were encouraged to build time into their daily schedules to establish their own personal mindfulness practice. Team meetings were also supposed to start with some mindfulness, to help practitioners reinforce a different way of relating to themselves, each other, and service users, which differed from the normal pace of work in their institutional context. As is evident in the intervision scene, however, this imperative to pause, to slow time down, constantly came up against the pressures of being located within a professional world that was anything but slow. Most of the POD practitioners I spoke with had not continued with a regular mindfulness practice after the training, and there was a distinct feeling of mindfulness being slotted in to meetings in a tokenistic way, far from what was intended by those who promoted it as a way to revolutionize care professionals' working modes. On the other hand, simply doing it at all, even for three minutes, differentiated the POD team from their colleagues, something often commented upon by those in the team who maintained a sense that they were taking, or had been given, some time to slow down, a precious resource in their context.

Urgency

POD practitioners often felt a sense of urgency underlying their everyday work, as well as erupting periodically in moments as the latest crisis would arise. Nadeem's mother's repeated calls to Faith marked one form of urgency that these workers often experienced – a request for them to act, quickly, to address others' distress. Taking time to slow down was not straightforward when time was punctuated by such requests, and the feeling that one must act to avoid possible tragedy. Audrey and Julia's comments responding to Faith's situation reflected precisely the sense of urgency that often structured their professional response to situations of crisis, a sense of time needing to move quickly that could not be set aside by POD's demand to slow things down. As POD trainers often explained, attempting to take time to listen and to talk with service users before acting was not always appropriate, and in situations where there was a risk of harm, quick action might be the correct course of action. Practitioners were asked, however, to keep in mind these different possible temporal modes of response: good care, in this approach, was to make a conscious decision about which of these was appropriate and safe, rather than to always rush to act quickly in response to crisis. As in the intervision, moving between these temporal modes, and making that decision, was also a negotiation of professional and personal relationships among colleagues, and thus was vulnerable to a team's group dynamics. One team member's feeling of being overworked, isolated or under-supported, could make others' desires to move quicker or slower appear as overbearing demands. At a later intervision, when the team reflected on what happened with Nadeem during the session described above, Faith reported feeling stressed by some of her colleagues' responses, humorously, but potently, explaining to Julia that she "could have punched her" when she came into the meeting late and demanded a faster response. In this case the team was able to reflect collectively on the event and the tensions it brought to the fore, but I observed other occasions when practitioners' divergent temporal and affective responses to professional pressures were left unresolved and contributed to some practitioners' decreasing longer term commitment to the POD team.

Longue durée

POD practitioners' relationships among themselves, and with service users and their family members, over a longer term, were consistently on the horizon in everyday negotiations of care. As exemplified in the "care coordinator" relationship, building rapport and trust over time was viewed as essential for being able to help someone "stay well." In the new therapeutic approach these care workers were attempting, this was thought to be enabled and improved by the different use of language and time in therapeutic encounters. The intimate and precarious

nature of this relationship was recognized by one senior team member (who did not hold a "care coordinator" role) who commented with a light humor, "if the care coordinator's blood pressure is okay, I know that I don't have to worry too much about a client." As Faith was experiencing, however, the enduring nature of this relationship held its own perils, as actions were anticipated to be held to account at a later point, for example in her fear about contacting the police and how it might transform Nadeem's view of her. Equally, the effects of the mental health worker's actions, whether it be in involving state authorities, or in encouraging a particular form of treatment, were held in view by practitioners who had seen enough service users struggle with the afterlives of past decisions. In the intervision this also manifested in terms of racial distinctions, as Rashida and Faith, themselves the two women of color in the meeting, noted how police might treat Nadeem, as a "big Asian guy," and why a decision to involve them needed to be taken with caution. In this sense, the longer term temporal modes manifested in this work were part of an extended trajectory through care, and moments of urgency or pause might have significant effects for how people navigate crisis that is not experienced evenly by all those involved. Those promoting POD often actively evoked this temporal horizon, suggesting that managing one's responses in terms of affective and temporal modes in clinical sessions and team meetings could transform the longue durée of mental health care into one characterized less by cyclical responses to short-term crisis, while also ultimately moving practitioners and service users out of the chronic crisis within which they find themselves caught.

(Ir)regular time

The pace of care work at stake here was marked by both regular commitments and irregular interruptions, both of which shaped practitioners' capacities to navigate the distinct temporal modes of their work. The weekly team meeting, the sound of the phone alarm bringing the mindfulness meditation to an end, the regularity with which service users needed to take medication, the limits on availability for therapeutic work imposed by shift schedules and annual leave, all punctuated the open-endedness of emotional presence POD practitioners were encouraged to cultivate. Thus, although in the training the approach was described as radically flexible, with practitioners encouraged to facilitate as many therapeutic sessions as needed, to last as long as they felt appropriate, POD teams quickly settled into a habit of anticipating that such sessions would last an hour and a half and arranging their diaries accordingly. The practicalities of working within a resource- and time-short system of care provision meant that such temporal boundaries were unavoidable. This was not necessarily a problem for the practice of POD, as the changes to the linguistic techniques used could still be made, but it did serve to remind practitioners of their institutional context and commitments that would impact upon whatever possibility POD presented for changing the forms of care offered. The predictability of this rhythm was also frequently interrupted, even destabilized, however, by the events and encounters which arose in practitioners' working days. The calls and messages from Nadeem's mother to Faith, the "crisis" of the service user Julia was working with which caused her to arrive late to the meeting, or the refusal of a service user to conform to the regularity of treatment plans and medication doses, were all ways in which relationships of care could be thrown off balance, and practitioners would have to swiftly recalibrate themselves. This contributed to the feeling of endlessness and exhaustion that my interlocutors often reported, in that there was a sense that the next interruption was always pending, but what form it would take or when it would emerge was uncertain. While POD encouraged practitioners to learn to "tolerate uncertainty" in recognition of this lack of control, the pervasiveness of temporal instability was continually challenging and rarely comfortable for those in its midst.

Collective and separate times

The gathering of the POD team for the intervision was one of the regular moments in which separate daily schedules and commitments of care workers who predominantly conduct their work alone would come together and attempt to move into the same affective and temporal space. This did not always occur in the way envisaged. In most meetings somebody would arrive late or leave early, perhaps somebody would leave the room during the discussion to take a phone call from a service user in crisis, or would be called away to attend the reception area where somebody was behaving in a disruptive or threatening manner. The attempt to collectively reshape the pace and nature of care was therefore challenged by practitioners' separate and different obligations. Differently, there was often a sense in which some participants were not "present" or "in the room" as much as others, meaning their participation in the meeting remained emotively detached or superficial; perhaps they upset colleagues when they responded to reflections with a dismissive tone or had not listened well to what was said. In this way the attempt to collectively reconfigure care's temporality in the practice of POD was always a work in progress, and moments in which team members felt deeply in tune with one another did occur and were poignant. But these moments were also transient and fragile, given demands outside of the space and time of team and network meetings.

Making crisis good

The question of the ethics of crisis, of what makes a "good crisis," is an exploration of the temporalities of care. Specifically, care in response to crisis takes the form of actions (or inactions) that are enacted and experienced over, through, or in time. This statement is true of diverse forms of care, and of social practices more broadly; but the framing of suffering by reference to crisis, in particular, narrows the temporal possibilities imagined by those experiencing and responding to it. POD practitioners' endeavors to work with and transform the notion of crisis into one that affords healing transformation, involving intimate and reparative affective relations – in short, to engage in relations of care in and through crisis – turn on how they navigate shifting temporal modes. In their attempts to turn acute psychological crisis around, while finding themselves stuck within the chronic crisis in infrastructures of care, they engage and struggle with diverse temporalities that are obscured in an overarching crisis narrative. Hence, making a "good crisis" out of both the paradoxical dualism of normative crisis narratives, and the unstable temporal modes that actually constitute their working lives, is an ongoing and laborious process. Making a crisis good by means of care, or enacting care through crisis temporalities, means enduring the difficult moves between, for example, conviviality and urgency, between the need to respond quickly and the imperative to pause.

Exposing and reframing "crisis normativities or crisis ordinaries" (Alexandrakis 2016:35) helps to explore the ambiguous ethics of care in times of crisis. When crisis is conceptualized not as an event which constitutes a radical break from the present, but rather as a manifestation of a process of "slow death" (Berlant 2007) or "slow motion trauma" (Alexandrakis 2016), we can rethink the affective relationship of the subject to acute, perhaps traumatic, life events. This is suggested by Berlant's idea of "slow death," understood as the chronic wearing out of a population seeking to maintain life under conditions of neoliberal capitalism, in which practices of self-actualization or expression are falsely ("cruelly") taken as manifestations of individual sovereignty (Berlant 2007, 2011). Casting the naming of crisis as a rhetorical move that locates responsibility for the severity of a situation in the individual bodies of those who live, and thus reveal, its effects, Berlant's "slow death" invites a reconsideration of temporalities of suffering, and thus care, in the face of structural violence. In Jasbir Puar's rendering of this notion via the language of "debility," we similarly move away from crisis as acute to shift attention to "the debilitating ongoingness of structural inequality and suffering" (Puar 2017:1). In being urged to recalibrate their relationship to therapeutic temporalities, POD practitioners' movements through crisis modes attend to the chronicity of slow death, or debility, thus conceptualized. In this context, the refusal of crisis normativities can manifest as a suspension both of the temporal impulses toward an

overdetermined future (Baraitser and Brook 2020) and of the "grammar" of crisis that maintains a dominant biopolitical order (Giordano 2020). Both of these forms of suspension rest on an ethics of care in which the acknowledgment of care's antithesis, or its failure, is central (Baraitser 2017). Care, Baraitser writes, "may involve the temporal practice of staying alongside others and ideas when care has failed; waiting, staying, delaying, enduring, returning, as the temporal forms that care takes." (2017:14) The co-existing and sometimes contrasting temporalities that Baraitser here notes manifest as care are also what POD practitioners navigate in their attempts to remake crisis as good. Not as a project of ethical self-making, as some anthropologies would have it (e.g. Robbins 2013), in which "the good" takes an aspirational form, but rather as an ongoing tussle with crisis normativities.

Engaging a Kleinian perspective on care as an ambivalent engagement with dread, guilt, and destructiveness, Baraitser avoids tropes of healing and redemption so often associated with understandings of care in crisis, and suggests instead that "knowing violence" is a way to push back against its continual perpetuation (Baraitser and Salisbury 2020). Against the urgency of action called for in narratives of crisis, other, as yet unknown, futures may in fact be able to emerge if care can be conceptualized as a form of waiting – or, in POD's terms, "sitting with" – in the present. Similarly, Cristiana Giordano invokes psychoanalytic temporalities to argue against the "narrative device" (Giordano 2020:77) of crisis as it relates to governance of migration in Italy. When the Italian state requires migrants to conform to a language of victimhood in order to access care, it reproduces an exclusionary, disciplinary politics, and the concept of crisis itself becomes complicit with the enduring, repetitive violence of the "refugee crisis." As an "interruption" to this politics, Giordano shows how certain artists' references to the idea of crisis refuse its "narrow logic of chronicity" (2020:91) by creating representations that expose its contradictions and "excess" (92). Pushing back against the counter-revolutionary force of crisis as both transient and redemptive, on the one hand, and as chronic and exhausting, on the other hand, rests for these authors on an attention to care as a set of divergent temporal practices, which otherwise often remain illegible.

What POD practitioners are doing when they grapple with these illegible, inconvenient temporal forms that constitute their encounter with crisis, is manifesting care as unsettled, ethically polyvalent practice (Cook and Trundle 2020; Murphy 2015; Ticktin 2011). They are also making crisis "good," however, insofar as they reconfigure the horizons of their own relationships and working practices in the troubled yet hopeful intersubjective modes that become possible in the interstices of crisis temporalities. The "good" here, does not refer to a moral end or a straightforwardly positive experience of striving and flourishing. Rather, here I conceptualize the ethical quality of their endeavors by reference to the reparative affects that emerge and persist alongside the constant destabilizations that make care necessary in the first place. A "good crisis," in this sense, is one in which acknowledgment and intimacy can be afforded in moments of care despite temporal pressures, shifts, and contradictions. That is, forms of relating that emerge when urgency can give way to pause, or time that is running out to conviviality. In the coexisting and contradictory temporalities of crisis also lie the unstable ethical potential of this work – as both implicated in the perpetuation of "debility" under conditions of austerity, while also affecting forms of reparation through acts of witnessing and "sitting with." By reparative affects I refer to Eve Kosofky Sedgwick's (Kleinian) notion of reparation as the impulse to feel pleasure and plenitude, despite a surrounding culture which is "inadequate or inimical to its nurture" (Sedgwick 2003:149). Translated into the context of POD, a notion of "good care" or a "good crisis" recognizes the precarity of hope in care (Denyer Willis 2020) and the imbrications of care with violence (Garcia 2010; Mulla 2014; Stevenson 2014), but also senses the ethical in a refusal of the redemptive teleology of crisis normativities. Thus, beyond resisting "crisis talk," as I noted above critical scholars have (rightly) done, POD practitioners' ambivalent engagements with it invite us to "sit with" the trouble of crisis, acknowledging its conservative, even debilitating, capacities, while also witnessing the forms of care that are constituted in the various temporal modes of connecting and affecting that I argue here manifest a form of reparative relation.

What we learn from their work is that the "good" in crisis is out of sync with the progressive telos toward which crisis narratives are predominantly oriented, and moves us beyond visions of either ethical purity or straightforward critique.

The ethnographic and analytical lens of the "good crisis" also serves to make legible temporal aspects of what is often unaccounted for in anthropological accounts of "the good": the forms of (affective) labor necessary in order to produce what is good. Care work within contemporary capitalism, as scholars have amply demonstrated, is labor that is distributed and performed unequally along lines of gender, class, and race (Boris and Klein 2012; Duffy 2011; Ehrenreich and Hochschild 2004; Glenn 2012; Yarris 2017). In the POD team whose meeting I recounted, these dynamics suffuse a gathering of women who extend considerable effort in caring for each other as well as the service users for whom they carry professional responsibility. Though there were some men who were part of this team, including the senior psychiatrist who held a managerial position, and was often absent from team meetings because of his other obligations, how these women conducted themselves as friends, nurturers, and peers to one another – sharing stories about motherhood or caring for parents or siblings, for example – reflected a form of gendered affective labor common in the POD community. In the positioning of certain team members as closer in life experience to certain service users – through the recognition of the racial dynamics of policing and coercive care; or in the likelihood that the person identified as the "peer worker" in the team was more likely to share a class background with many of the service users – making a crisis good relies upon the differential ways that practitioners are able, or expected, to relate to and "sit with" the experiences and suffering of others. Navigating different temporal modes to achieve the desired affects required deft maneuvering of these dynamics, a practice differentially demanded across the POD community, as in other fields of care work, in order to produce what was "good" about this conceptualization and experience of crisis.

In this sense, I seek to harness this ethnography of crisis to reframe what we can do with the category of "the good" in the anthropology of care, to reclaim it from redemptive teleologies and situate it instead alongside those analyses of the emergent, the precariously hopeful, and the vital, which persist amid disappointment and destruction. That is, taking into account the inequalities, ambivalence and potential violence of care, need not imply a refusal to acknowledge the ways our interlocutors "make good" in moments of failure and distress. Making crisis "good," for these carers, involves the ongoing failure to reach the desired critical turning point and yet the experience of meaningful attachment and transformative affects that surface and then might recede again, as they inhabit the temporal forms that the crisis ordinary takes. Not only reformulating their words and refining their embodied clinical presence, POD practitioners also resituate themselves in and through time, making care about the act of pushing back against the imperative of urgency, for example, or that of making time available for others even when their own is running short. Making good of a crisis, in this case, means both inhabiting the ambivalence of the ethics of care, and refusing narratives of redemption which perpetuate crisis as chronic and stuck. This is a different imaginary of the good crisis than that I cited at the beginning of this article, in which political actors suggest we "not let a good crisis go to waste," an approach which offends because the way it harnesses the "good" works to obscure of distress in its temporal leap to the time beyond crisis. Rather, here, a good crisis is one in which we know the violence and the failure of care, but where reparative affects can be sensed in the temporal interstices of this failure. In making the good in crisis thus, these care workers demonstrate how staying with its temporal contradictions and troubles opens ethical horizons within and beyond our current, crisis-stricken, time.

Notes

1. https://www.theguardian.com/politics/live/2020/sep/28/uk-coronavirus-live-politics-covid-19-latest-news-updates?page=with:block-5f71c49e8f08693b1774f912#block-5f71c49e8f08693b1774f912.
2. https://www.theguardian.com/politics/live/2020/sep/28/uk-coronavirus-live-politics-covid-19-latest-news-updates?page=with:block-5f71c49e8f08693b1774f912#block-5f71c49e8f08693b1774f912.

3. Two key adjustments in the UK context have been: 1) the involvement of peer support workers, who are explicitly recognized as having 'lived experience' of mental health services themselves, and who use this experience in their therapeutic encounters with other service users; 2) the practice of mindfulness by POD practitioners (Razzaque 2015, 2018).
4. Clinical Commissioning Groups are the decentralized organizations, constituted of groups of primary care physicians, made responsible for planning, commissioning, and monitoring healthcare services across England by the 2012 Health and Social Care Act under the coalition Conservative-Liberal Democrat government. They manage a large proportion of the state healthcare budget and work on a contracting basis, purchasing the provision of healthcare services within a government-regulated market.

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