Personal Continuity of Care:

The imperilled crux of our mental health services

A letter to the Secretary of State for Health and Social Care

David Zigmond

Will more funding, training and management necessarily improve our mental health services? Are there major factors we are still set to neglect? And will these then stymy our efforts and investments?

Dear Matt Hancock MP

Personal continuity of care: the imperilled crux of our better mental health services

Last week's (10.10.18) news could sound good for turning around society's blight of increasing mental health problems: we had a World Mental Health Day and you hosted the first-ever Global Ministerial Mental Health Summit, in London. Governmental buttressing came from the Prime Minister talking of '[mental health's] burning injustices in our society' and pledging to 'end the stigma that has forced too many to suffer in silence'. A new appointment of a Suicide Prevention Minister seems to focus this resolve, as did your radio interview (BBC Radio 4 *Today*, 10.10.18) itemising government leverage: more adequate funding, more trained specialists, more research…

All of this might be grounds for optimism if our boosted investments are on the right path. But are they?

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I have served as an NHS doctor for several decades as both a psychiatrist and a GP Principal. The views I express here come from long exposure to the fate of individuals and their managing institutions. My views are widely held by my generation of practitioners, yet less commonly publicly expressed: my peers mostly now are either retired, with relief, or are working wearily with stoic and demoralised detachment.

So even if we confine our view to the mental wellbeing of doctors, our current path does not seem a good one. Why?

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Most senior healthcarers agree[1] with the following epigram capturing the course of recent decades of the NHS: *all that is determined by technology is better. Almost everything that depends upon personal relationships and understanding is worse.*

This has had very serious implications throughout pastoral healthcare, especially in General Practice and mental health. Why? What has happened?

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Improvements in technological medicine are indisputable and often dramatic, but this has often been at the expense of valuing personal relationships and meaning in practice. So we have become very good at mass-management, standardised and scaled-up protocols, and tight systems of governance. But for both practitioners and patients this has usually been achieved by sacrificing of personal continuity of care: the service has become increasingly defined by atomised tasks rather than beneficent relationships.

Consider these examples from reforms in recent years:

- The Quality Outcome Framework (QUOF) to remunerate GPs; the registration of patients with a place (a practice) rather than, as previously, with a person (a practitioner); the all-but-coercive closure of small practices; the increasing tendency to management by commercial companies rather than vocational

practitioners – all of these obstruct, distract or fragment the possibility of personal continuity of care.

- In mental health services reforms have compounded the systemised depersonalisation and anomie found in General Practice. Increasing the number and types of specialties, diagnoses and teams often leads to *poorer* personal engagement, containment and understanding. What evolves instead is systems-directed: a complexly fragmented and relayed form of processing patients with frequent boundary problems and pullulating bureaucracy. Defensively 'correct' procedures become more evident than genuinely healing encounters.

- Commissioning and then marketising 'providers' for mental health and primary care is bound to be destabilising, and will further depersonalise any possible personal continuity of care. This happens because corporation and vocation have very different motivations and energies.

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The result of such 'efficiency' reforms? Few patients now can name the GP, psychiatrist – or even psychologist – they last saw. What sort of human engagement are we providing?

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Yet it is the quality of human engagement and understanding – more than anything else – that contains, comforts and sometimes can heal our kaleidoscopic mental anguish.

Neuroscience – now much vaunted – in fact contributes more as a kind of analytical translation than any effective balm or 'cure'. Why else is mental dis-ease and illness

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both increasing and remaining so refractory to definitive treatments, despite so many new drugs and techniques? Why can our advances here never remotely match those, say, of vascular or ophthalmic surgery?

The answer is because so much of any therapeutic benefit we may have to offer the mentally anguished comes from its human nature and sense. And this nature and sense – when well attuned – generally can deepen and grow only with personal continuity. Such stability and familiarity is like the soil in which attachment, containment and affection may grow. And it is from these that our therapeutic fruits may then come: the repair of our wounds, the growth or our capacities, and the development of our resilience to life's stresses, sorrows, and – not least – our own contradictions and complexities.

These lasting changes are much less likely to come from interventions that are primarily medical, procedural or behavioural – the husks of mental healthcare that are left if we remove its relationships and meaning. Yet such personal evisceration is largely the effect of our serial reforms – both on our pastoral healthcare in general, and our mental healthcare in particular.

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Lack of funding or staff can certainly make our better personal and pastoral healthcare impossible. But merely providing more money, training and staff does not necessarily assure this better care: not if – as currently – we have systems that themselves are destructive or inimical to human attachments and understandings. Conversely, a system's hospitality to personal continuity of care is a good index for the wholesome flourishing of these things. But an ailing, struggling service with poor staff health, morale, retention and recruitment is a reliable sign of their absence.

This latter scenario is our current situation in mental healthcare, and where we are in danger of heading – even with more resources.

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So how do we reclaim and safeguard these better personal qualities for our health service in general, and our mental health services in particular?

I recently wrote a missive for the King's Fund: *Industrialised healthcare: how do we replant our human sense?* At the end of this, in Section 13, I list some suggestions.

Amidst your many responsibilities I hope you will find the time to consider these alternatives: I am, of course, interested in further dialogue.

Yours sincerely

Dr David Zigmond

Note

1. I have had positive feedback from many veteran practitioners (and patients) on hearing this epigram: 'Yes, that's just what has happened …!' is typical.

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Attachment
Industrialised healthcare: how do we replant our human sense?

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