Managed care models are hurting the UK's mental health system

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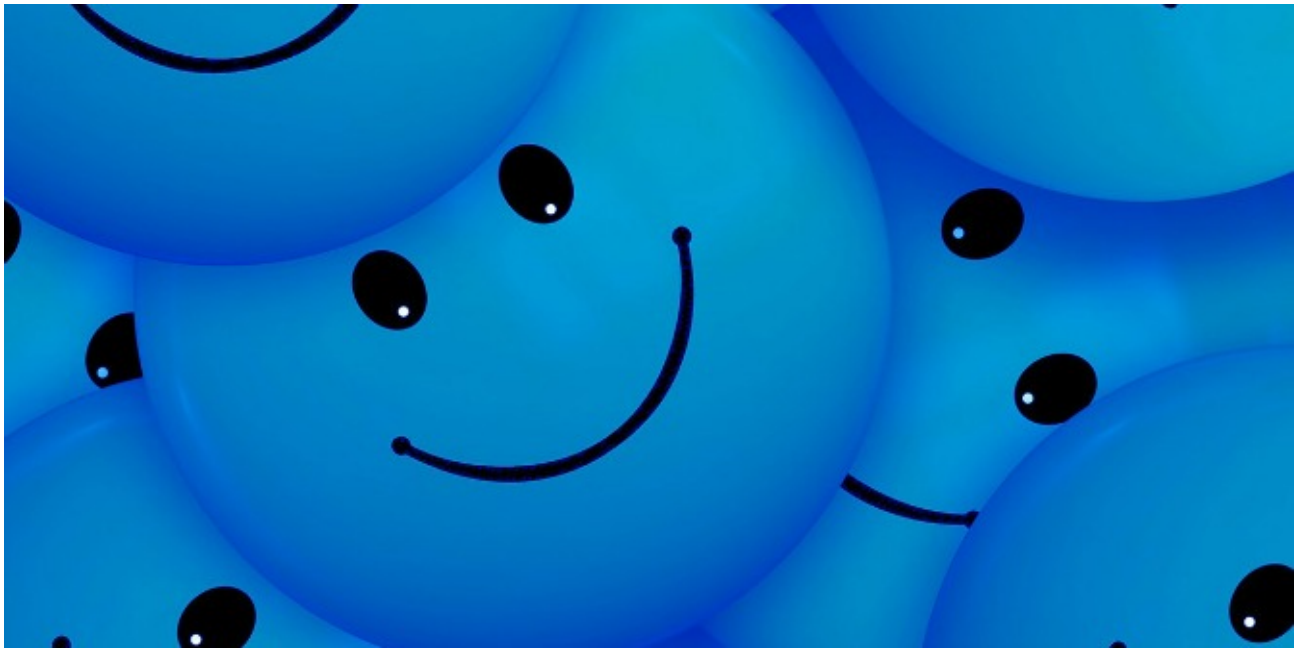

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Although neoliberal economic theory purports to promote equality through unfettered free enterprise, this is based upon a false premise. We are not 'all in it together.' The inequality between the 'haves' and the 'have-nots' means that everyone does not start from the same position. In fact, as many eminent economists, including leaders at the IMF and World Bank, now recognise, increasing inequality has seriously adverse consequences for the productivity, wellbeing and effectiveness of any society.

The cultural paradigm lying behind the UK's mental health system is rooted in neoliberal political and economic theory which argues that unfettered free enterprise, elevating self-interest over social and group needs, will optimally organise every facet of society, including mental health and social life. This is a belief system founded upon empirical, scientific principles, which conclude that the nature of reality can be understood by behavioural and materialistic theories of human development, discoverable by a particular form of evidence-based research, like randomised control trials.

Of course, evidence-based approaches are not bad per se; it is rather how the 'evidence' is construed and how alternative approaches or models are dismissively excluded which is problematic. The validity of the 'evidence-based' research culture is based upon a series of dogmas which fuel a fantasy of discovering a 'perfect', all encompassing understanding of how we function together, dangerously over-objectifying and reducing, rather than valuing, what is human.

My argument is that it is essential that this model is countered and mediated by a wider, more inclusive socially oriented group-relational understanding of how we live and interact together.

Cognitive Behavioural Therapy

The current trend in social and mental healthcare systems is dominated by the ethos of a structural managed care model which prioritises manualised, individually oriented and focused clinical treatments, and the dominant model of Cognitive Behavioural Therapy (CBT) in the NHS. Imposing this model is, in my view, ethically and professionally misinformed. In its attempt to reduce anxiety and risk it actually does the opposite and creates conditions which increase anxiety and perversely cause trauma, resentment and a reactive defensiveness in staff.

The predominance of CBT as the panacea for mental distress sustains this fantasy that society's ills can be contained within one limited model and views them as technical problems or medical illnesses, as if they were individual problems, divorced or separate from the social culture and context within which they occur.

Managed care models foster a cultural context where health and wellbeing become commodified and the human relational elements, which are intrinsic to care, become devalued. Tasks are organised with other aims in mind, like targets and depersonalised procedural mechanisms and this can create a context which distances clinicians and care staff from each other and from personal contact with those they care for.

Under the managed care model there has been an explosion in middle managerial jobs largely at the expense of clinical ones and, as a consequence, this has seen a large increase in the pursuit of 'targets' and bureaucratic imperatives. As these are driven on by centralised directives, designed to increase efficiency and throughput, pressures increase upon clinical staff to fulfil what seem like incomprehensible and clinically irrelevant bureaucratic tasks, which, notwithstanding the necessity for properly evaluated practice, are extraneous, unnecessary and stultifying.

A disparity develops between the aims of the managers and administrators and those of clinicians. This is experienced as an imposition from above with little apparent concern for what is actually required to address the pressures of managing the clinical work. Staff stress is increased and levels of anxiety are raised.

Our anxiety increases if we are asked or required to do something we are unable to do because the conditions and the context of the working environment conspire to thwart us in the task. This can lead to situations where financial cuts are implemented in the name of efficiency and staff are still expected to maintain the same work levels with less resources available. If overstretched and overworked staff are asked to achieve unrealistic targets or are compelled to do clinically irrelevant paperwork, if staff are put into situations which leave them feeling impotent and traumatised in the face of patient needs by reducing the type or length of treatments against their professional judgement, then, of course, anxiety will increase.

If we sanction a health care system based on a business model where profit is the motive for efficiency or the rationale for decisions about resources we get one where the desire to reduce financial cost pressures triumphs over ethical, professional and clinical judgement. If we sanction a health care system where financial incentives are the priority we get a system which is likely to become less concerned about staff and patient needs and more likely to cut corners to maximise profit.

An alternative model

Group analytic theory and practice emphasise the social and relational nature of human beings and our essential interconnectedness. This is not to say that the social or group to which one belongs takes precedence or is elevated above the individual. In essence the focus is upon our interdependency. The aim is to consider the relationship between the individual and the social group as intrinsically and actively linked together dialogically in meaningful interaction. This is an open-ended, emergent process, which requires a safe-enough containing context to thrive, integrating and promoting healthy biological and social processes. A prerequisite for the establishment of any social care system should be based upon a bio-psycho-social understanding of human relationships.

Someone presenting with a mental health problem, for instance, should not be seen as only bringing a separate

individual problem. Their problem represents only one aspect of an intricate and complex social/group phenomenon. Individual disturbances should be located in all the aspects of a person's life and in their network of interpersonal relationships. We cannot conceptualise or consider individuals as if they were in isolation from the formative, social and cultural context in which they live and work.

A group analytic understanding is an essential prerequisite to enable healthy containment of anxiety, both for the individual clinician and for their colleagues in the working setting. The fundamental basis for social care systems and for communal life must be the acknowledgement of our interconnectedness in the living and working environments we share together. An organisation does not exist as a thing outside of ourselves. It is a dynamic, creative, evolving construct, which emerges in the relationship between the people who form it and are formed by it in lived experience.

I spent most of my working life trying to establish and develop with colleagues a safe enough context to optimise the therapeutic potential for staff and patients, in a psychotherapy service in a major teaching hospital. A lot of my time in the latter years was spent defending and protecting staff from the ever increasing imposition of bureaucratic measures, ostensibly designed to improve efficiency and the containment of anxiety generated by the pressures of our workload. As resources were being reduced and a new model implemented from above, this created an intolerable situation for clinicians as they struggled to look after the patients in their care and, equally as importantly, to safeguard their own health and wellbeing.

Of course, like any reasonably sized service with a hierarchical pay and status structure in place and the inevitable professional and personal dynamics colliding as they do, we were far from perfect. However, we were able to deal with and contain these at a manageable level because of the sense we had of the basic requirements needed to underpin and stabilize our working model.

This was based upon a set of holding principles formed by an analytic and thoughtful holistic understanding with reflective spaces for staff, which facilitate thinking and working through issues and difficulties and, most importantly, the maintenance of a safe enough/good enough context as a container that will hold staff and patients together throughout these processes. We were informed by our training and professional practice, which enabled us to move towards an understanding, reinforced by experience, that containment and holding staff and patients was a social phenomenon, embedded in our interrelatedness and connectedness rather than one which focuses solely or primarily on individual psychopathology or target-driven results.

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Notes:

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