Editorial

Oliver Dale, Rex Haigh, Julia Blazdell, and Faisil Sethi

Social psychiatry, relational practice and learning from COVID-19

Summary

This piece reflects on the impact of institutional responses to the COVID-19 crisis on UK community mental health services. The pandemic provides a unique learning opportunity which highlights the need for a more relational way of working in community psychiatry as part of a reinvention of social psychiatry.

Oliver Dale is based at West London NHS Trust, Southall, UK. Rex Haigh is based at Berkshire Healthcare NHS Foundation Trust, Reading, UK. Julia Blazdell is based at West London NHS Trust, Southall, UK. Faisil Sethi is based at South London and Maudsley NHS Foundation Trust, London, UK.

Policy context

The NHS Long-term Plan (LTP), with a focus on tackling inequalities, is well underway. 2019 brought the NHS Mental Health Implementation Plan and the Community Mental Health Framework alongside emerging models of integration around Primary Care Networks. These envisioned a more continuous, stepped-care community provision with an ambition to give the marginalised a voice through co-production, personalisation and integration.

As COVID-19 appeared in December 2019, the Royal College of Psychiatrists was preparing its first college-wide position statement on services for people diagnosable with personality disorder (Cross Faculty Working Group, 2020). A journey which started in 2019 with the critical "Consensus Statement on Personality Disorder" (Lamb *et al.*, 2018), the launch of the January 2020 position statement was designed to give the Royal College's concrete recommendations in support of the LTP.

Pandemic

The world in 2019 was different. Even as the World Health Organisation declared a pandemic in March 2020, we had little idea of what was to come. We now know the medium-term is volatile, uncertain, complex and ambiguous. We suggest, however, that an agenda built on co-production should withstand the test of these times. While COVID-19 prompts us to review our procedural systems, a focus on community support for people with complex mental health difficulties is just as relevant. So it is right to ask what changes we might make to the approach set out in the position statement. One amendment we might make is to articulate the role of social psychiatry and its clinical component, which we are calling *relational practice*. This is where the formation and maintenance of therapeutic relationships, and sometimes the wider therapeutic environment, are given priority over standardised procedures.

While the pandemic brings new challenges, it also highlights pre-existing failings and inequalities. For those working in a community setting, our normal structures and processes were blown away. Although a hugely disruptive experience, an unexpected benefit may be that services' component parts being thrown up into the air, leaves a clearer view of the nature of the work. One such component was relational practice which describes the way in which everything we do is held within a relational field. As such, the relational context is a key component of what translates an intervention's efficacy into effectiveness, irrespective of whether the intervention is biological or psychological.

Declaration of interest: The authors do not have any declarations of interest to make.

The pandemic had an immediate impact on community services. Routine work ceased; of note was the scaling back of psychology and psychotherapy treatments, with the only continuity being that some established work was allowed to carry on in modified form, such as by phone or video sessions. The drive to ensure business continuity threatened to end clinical relationships as we moved to services focussed on crisis management and prevention of serious harm.

Our response to the pandemic undermined the fabric of our relational framework. Some of us working on the frontline argued for continuity of clinical relationships and the team structures required to maintain them. When challenged, we explained our relationships were our most valuable clinical asset, and the power of relationship was as effective as medication or therapy. Our resolve prompted us to examine the nature of our work, both in terms of what we do and how.

The physical act of social distancing and the notion that being with others is a threat, thrust this aspect of our work into the spotlight through its impact on our relationships. This could yet be a silver lining to our COVID-19 cloud, as the salience of our relationships and social psychiatry has never been so obvious. It also helped elucidate a troubling criticism of our prevailing clinical model which seems unbalanced, with bio-psycho approaches almost eclipsing the social and the bio-psycho-social.

Social psychiatry

When social psychiatry was last in ascendance, the concept of extramural psychiatry was concerned with the dissolution of asylums. Progress lay in approaching our patients as having both healthy and unhealthy aspects; that we needed as much focus on function as symptoms and less on protection. These ideas paved the way for thousands of individuals to live fuller lives in the community. And herein lays the contribution of social psychiatry, which is not about *doing to* but *getting alongside*. Social psychiatry moderates the limitations of the bio-psycho approaches through not trying to change the patient and by accepting them and supporting them in their community. It demands of us a public health approach which accepts variable outcomes and adopts a systems-wide strategy by creating "enabling environments" (Haigh *et al.*, 2012). This requires tolerance of complexity, chronicity and, even in some cases, an appreciation of palliative approaches.

Some versions of the recovery model have argued that clinical relationships are another form of institutionalisation and, because they are seen to be driven more by our own needs, any emphasis on them is counter-therapeutic. Exacerbated by austerity, we are pressured to provide discrete interventions to patients as if they have discrete illness entities, often designed to promote flow through the system and a speedy discharge out of it. Such oversimplified and optimistic rhetoric is probably motivated by our unspoken despair in trying to help those with serious lifelong problems. A singular focus on treatment and cure is harmful – as we continue to define pathways which many of our patients are unable to follow. Such a process-orientated approach may bring cost-effective benefits, but we must also provide for those for whom such an approach is unrealistic.

The personality disorder consensus statement highlights the continued concerns about this. For some, it seems that we have simply created invisible walls and a new form of total institution. A "glass asylum" exists for those who are not amenable to our treatment packages. For clinicians working with personality disorder this is especially pertinent; the disorder, with all its disruption of relationships, is driven by the shadow of early adversity falling upon the adult. There is no cure for what happened to an individual, and to be truly trauma-informed means our task is aimed more towards *dis*covery than to *re*covery.

Relational practice

Practising relationally is so much part of everyday life that we barely notice it; it is the space between things, an interstitial ingredient, so is difficult to capture and measure.

Although continuity of care is only a part of relational practice, empirical evidence demonstrates how it reduces all-cause mortality (Gray *et al.*, 2018), as well as a dose-dependent relationship with admission avoidance in primary care. In psychiatry, good therapeutic relationships can bring coherence and hope: if we get this right, there are considerable systemic gains.

It is the nature of community psychiatry as container which best illustrates the role of social psychiatry and the relationships within it. The clinical work often begins from a place of crisis, which sometimes means having to wait for one, before we start. While we know crisis brings opportunity, these situations undeniably have an air of failure and fear. For some patients, the drivers towards crisis are never resolved and resurface at transitional points in their lives; for them, therefore, the work is life-long, just as our relational connection with them needs to be. The CMHT is, therefore, quite a battered container, especially as success is largely silent.

The nature of containment, in terms of what is being contained and by whom, makes it feel confusing, sometimes threatening and undoubtedly hard. Our task is to help patients accept painful truths and provide genuine relief through our continued relational presence, which can mean having to bear despair and shame. It can also mean confronting a profound fear that owning these aspects of themselves will almost certainly lead to rejection or pain or humiliation, just as they experienced in early life. Finding a home in which these parts are accepted is the task of the therapeutic container and the journey towards some degree of integration.

This is necessarily a relational process and psychotherapy's "Common Factor Theory" recognises the importance of the *real* relationship, as opposed to a specific therapy technique. Such a relationship is private but not secret; it allows disclosure of difficult material through seeking to understand and not to judge; is valued by both parties and not ended unilaterally; is truthful and personal yet professional; it is curious and inquisitive but not overly directive. It demands what therapeutic communities call "a culture of enquiry". If we achieve this, we become as, Linda Gask describes it, the keeper of the story (Gask, 2018). In doing so, we facilitate self-acceptance and give an experience of belonging; in resisting rescue, we empower.

As we respond to the challenges of the COVID-19 situation, the exceptional nature of the pandemic could help us to incorporate the relational practice of social psychiatry and the public health approaches of prevention into community care. The NHS LTP and position statement provide practical ways in which to approach the challenges we face through a reinvented social psychiatry approach in a modern functionalised system. Success here promises a more humane mental health system.

References

Cross Faculty Working Group (2020), "Services for people diagnosable with personality disorder", available at: www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_20.pdf?sfvrsn=85af7fbc_2

Gask, L. (2018), "The keeping of stories. Patching the soul", available at: https://lindagask.com/2018/07/29/the-keeping-of-stories/

Gray, D.J.P., Sidaway-Lee, K., White, E., Thorne, A. and Evans, P.H. (2018), "Continuity of care with doctors – a matter of life and death? A systematic review of continuity of care and mortality", *BMJ Open*, Vol. 8 No. 6, p. e021161, doi: 10.1136/bmjopen-2017-021161.

Haigh, R., Harrison, T., Johnson, R., Paget, S. and Williams, S. (2012), "Psychologically informed environments and the 'enabling environments' initiative", *Housing, Care and Support*, Vol. 15 No. 1, pp. 34-42.

Lamb, N., Sibbald, S. and Stirzacker, A. (2018), "Shining lights in dark corners of people's lives", *The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder*, available at: www.mind.org.uk/media/21163353/consensus-statement-final.pdf

About the editors

Oliver Dale is a Consultant Adult Psychiatrist in the Treatment and Recovery Team in Hammersmith and Fulham, West London NHS Trust.

Rex Haigh is a Consultant Medical Psychotherapist for the Assertive Intervention Stabilisation team in Slough, Berkshire Health Care NHS Foundation Trust.

Julia Blazdell is a Service User Consultant in the Managed Clinical Network for Personality Disorder, West London NHS Trust.

Faisil Sethi is a Consultant Psychiatrist in Psychiatric Intensive Care at the Maudsley Hospital, South London and Maudsley NHS Foundation Trust.