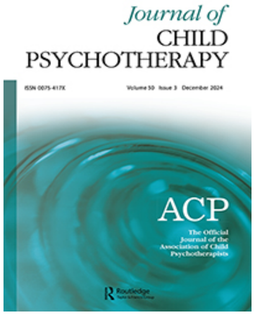

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(Overcoming) attacks on thinking: the importance of psychoanalytic thinking in surviving systemic fragmentation of the public mental health sector

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ABSTRACT

In the last 15 years, the public mental health sector has been subject to two big policy shifts that have impacted the ability of Community Mental Health Teams (CMHTs) and Specialist Child and Adolescent Mental Health Service (CAMHS) clinics to deliver therapeutic services. This paper discusses the impact of the Improving Access to Psychological Therapies (IAPT) policy and the Health and Social Care Act (2012) on these services and the various barriers to effective treatment that they have created. The author then proposes that, as psychoanalytic psychotherapists, with our particular awareness of unconscious and group processes, we are well-placed to support multidisciplinary colleagues in overcoming feelings of hopelessness, anxiety and impotence that these policy shifts create and takes inspiration from potentially analogous situations with patients as a method to approaching the systemic aspects of our work.

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Splitting; systems; health policy; IAPT; community mental health

This paper seeks to consider the state of mental health services within the NHS at the time of writing, with a view on both the present struggles and how this situation has arisen. Two public health policies have resulted in large-scale change in the UK's mental health provision over the last 15 years. The first is the 2008 Improving Access to Psychological Therapies (IAPT) partnership between the Department of Health and the Treasury; the second was the Health and Social Care Act (2012). The ways in which both policies have redefined the ability of community mental health teams to provide comprehensive care in the public sector are described herein. There will then be a discussion of how psychoanalytic psychotherapists also have the skills to support teams and adjacent services, in surviving the phantasies, and realities, of the fragmented systems and governmental attacks on thinking that have resulted from these structural impositions on mental health delivery. It is worth noting that difficulties existed in public mental health before these legislative changes, with the Sainsbury Centre for Mental Health raising concerns about the risk of patients being discharged, 'inappropriately early,' and of 'cream-skimming' where services avoid treating more

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complex or severely ill patients in preference of ‘easier and cheaper cases’ (2004, p. 6). The author’s experience in different NHS Trusts, and a number of Child and Adolescent Mental Health Services (CAMHS), is entirely under the IAPT timeline, and this paper was initially written as part of a conversation with senior managers within a mental health trust, hoping to open a reflective space to combat some of these systemic difficulties. It is adapted here in the hope that it might usefully inspire or facilitate such potential movement elsewhere.

IAPT

The case for Improving Access to Psychological Therapies (IAPT) was initially, and in many ways continues to be, an economically-driven policy (Knapp et al., 2011; Layard et al., 2007; McCrone, 2008), which promised to save the Government money by encouraging many chronically unwell people (often claiming incapacity benefits) to access therapy and return to the job market. The intention was that, with access to psychological therapies, their productivity and taxes would contribute to economic growth and ultimately a cost saving. The programme created £173 million of funding, as an investment towards a promised 20% overall saving in health spending for GPs alone. The aim was clear from the Commissioning Guidance (Department of Health, 2008b) that IAPT would deliver, ‘NICE-compliant therapies,’ (section 5.2) which were ‘commissioned for outcomes,’ with services’ funding dependent on positive outcomes being provided to commissioners (section 8.1.). It also made clear that *all* mental health services run within the NHS would, sooner or later, be required to become IAPT services. When the Health and Social Care Act (2012) was later enacted, all NHS mental health trusts were required to comply with the IAPT specification and to submit their outcome data to commissioners under Section 259 of the Act. This has caused additional burden on clinicians, at a time of decreasing real-terms resources and potentially contributes to the reported decrease in staff morale (Deakin, 2022). It has, however, also been a successful policy in its main stated intention to increase access to mental health services (NHS Digital, 2024).

While the IAPT policy encourages commissioners to follow the National Institute for Health and Care Excellence (NICE) guidelines, it also strongly encouraged services, at the time of its launch, to be predominantly based on either ‘low-intensity’ or ‘high-intensity’ Cognitive Behavioural Therapy (CBT) or computer-delivered CBT (cCBT) and ‘recommend[ed] CBT for all conditions’ (Department of Health, 2008a, p. 8) confirming that it ‘will be the most widely used therapy in the new service’ (2008a, p. 9). It might be that the push for CBT as the main (sometimes only) intervention within the IAPT plan was to guarantee only evidence-based, NICE-compliant therapies were offered. However it also supported a workforce development shift that aimed towards a mostly, ‘new,’ labour force, heavily weighted towards band 4 (2008a, p. 11) a significant cost-saving on the typical clinical complement of band 6 mental health nurses, or clinical psychologists on band 7 or 8a.

The Health and Social Care Act (2012)

Shortly after the IAPT policy, the coalition government introduced The Health and Social Care Act (2012) which overhauled the way that NHS services were commissioned within England. It moved the responsibility for providing NHS services from Strategic Health Authorities and Primary Care Trusts to regional, 'clinician-led' Clinical Commissioning Groups. David Cameron's coalition pledge of 'parity of esteem' between physical health and mental health was facilitated by the Act and thus encouraged commissioners to fund mental health much in the same way as physical health. In this model, the commissioners determine what they believe (the clinician-led part) is needed in their locality and then publish the specifications of a service that would meet these needs, open to any entity to bid for. Child and Adolescent Psychotherapist Andrew Briggs has described in his 2018 paper 'Containment lost: the challenge to child psychotherapists posed by modern CAMHS' how NHS services are now businesses, and that the combination of this change, and the tendering process, leads to a conflict of both life and death instincts, systemically baked-in to these services. The business that wins the tender will have designed a service that meets the requirements of the commissioners, and 'these services are also designed so that Trust senior managers can control them,' in order to remain, 'viable'. Briggs argues that what *actually* happens, is the design of, 'services that are devoid of this strength of the life instinct since […] minimising risk and waiting times, diagnosing for simple care pathways and so on, mitigate against complexity and relationship' (2018, p. 172). Unfortunately, this means that modern NHS services are designed for survival of the service itself, and not to meet the complex needs of the service users.

Increasingly, the impact of these changes also means that there are dedicated pockets of funding for ever more specialist services; mental health trusts hosting separate neurodevelopmental services with their own pockets of funding, and the same goes for eating disorders, psychosis and so on. This leads to what has been called a 'splinter and fracture' of the collective nature of the NHS and that, '*Intra*-sectional interests won out over *inter*-sectional concerns […] intended to constrain autonomous professional practice' (Speed & Gabe, 2020, p. 47). This legislative change, and the constraint on autonomous clinical practice, turned NHS services into 'businesses', which became, 'directed towards working within tight financial budgets, accurate and detailed performance reporting and controlling for other risks to the reputation of the business' (Briggs, 2018, p. 169). The clinical work in these businesses is now reduced to risk assessment, diagnostic assessment (deciding which IAPT treatment should be offered), 'and a seemingly endless amount of time' (Briggs, 2018, p. 169), spent ensuring that data on risk and performance is captured on the IT systems.

The impact of 'parity of esteem' has therefore seen an accelerated shift towards a medicalisation/biologisation of mental health; that policy decisions should now be based upon 'the application of knowledge derived from empirical research – on the model of the biomedical sciences … assured through systematic evaluation' (Cooper & Wren, 2012, p. 199). The argument goes that, if the robust, controlled, scientific evidence shows treating type-1 diabetes with insulin is near-100% effective, then treating depression should have the same, 'evidence-based' intervention. From this position, when a patient visits their GP with a diabetes-related problem, they might expect to be referred to a specialist diabetes nurse; likewise the expectation increasingly exists to be seen by a mental health professional who is an expert in specific presentations, and may need little awareness of mental health beyond one niche disorder or therapeutic intervention. Unfortunately, as the next section of this paper will explain, the collective evidence that are relied upon for these decisions in mental health rarely translate from the research protocol into the real world of patients.

Outcomes and 'evidence'

There has long been discussion about whether the medical model of care pathways based entirely on the presence of symptoms is effective in adult mental health care, but this argument is more important for children's services (Isobel, 2024). The convergence of mental health awareness, the policy of 'parity of esteem' and the prevalence of social media use have made this a more challenging issue for therapists, and quite likely support such a diagnosis and treatment focused structure through patient coproduction of services. Where young people arrive with a self-diagnosis via social media, obtained by consuming affirmational content from influencers, coproduction of care plans and patient choice is likely to direct treatment in the wrong direction, based upon reports of symptoms that match these self-diagnoses. This is a trend noted by child psychotherapists Acheson and Papadima (2023), describing the 'unwell persona', where 'adolescents come to us with fully formed mental health identities and diagnoses' (2023, p. 98). A 2023 review of social media mental health content indicated that, of the 500 most popular mental health influencers, less than 10% had a mental health training and more than three quarters of videos were actively misleading (14% were described as 'potentially damaging') (Sood, 2023). Unfortunately, one impact of this more medical approach is that it strips social, domestic and personal circumstances from the understanding of mental health (Callaghan et al., 2017). A 'slowing down and opening up' (Acheson & Papadima, 2023, p. 98) becomes increasingly difficult, and the service drives towards a collective disavowal[1] (Freud, 1918) of the nuances involved with mental health difficulties; 'Complexity is not recognised. The relationship context for patient symptoms and treatment is not recognised' (Briggs, 2018, p. 169). It is as though different possible causes of depression, anxiety or other common complaints can no-longer be known, or that different treatments are equally required to address these differences, despite it being concurrently impossible to ignore these facts. Instead, a choice has been made in favour of a 'fetishisation' (Rizq, 2014) of governance, outcomes, evidence and 'science', while undermining effective, meaningful, interventions. In both the NHS system, and in the work with patients, 'the flashing lights [of crisis] cause us to lose sight of what lies beneath' (Acheson & Papadima, 2023, p. 115).

What lies beneath, however, varies from patient to patient, and while patients may increasingly be, 'interested in the language of diagnosis' (Acheson & Papadima, 2023, p. 98), which converges with a push towards medicalisation, meaningful outcomes and ways to measure them become increasingly difficult. Indeed, as Rizq describes in an encounter with a patient, 'she didn't really think that the "outcomes" on the form were the outcomes she was interested in' (2014, p. 250). The suggestion, therefore, is that the outcome-focus of the IAPT policy and the outcome reporting of the 2012 Act is misaligned with the actual therapy experiences of the patients it serves, and while the IAPT policy allows for Trusts to negotiate with commissioners about what outcomes should be reported on, this overlooks the fact that different therapies might require different outcome measures to demonstrate progress.

Jonathan Shedler (2018) has written extensively about how the 'systematic evaluation' of psychological interventions to provide 'evidence-based' therapies within the NHS is *far* from scientific proof, with therapeutic interventions delivered by untrained research associates, lack of reliable follow-up data, and change based on questionnaire-based thresholds rather than patient experience or psychiatric diagnosis. He has also detailed how (Shedler, 2010) such research is often artificially contrived and often supports the 'Dodo-bird verdict' (Rosenzweig, 1936) where 'everybody wins' and there is no difference between interventions. This absence of 'real' evidence and evidence-based decision-making (Greenhalgh, 2015) creates two problems for NHS mental health services. Firstly, the fact that the research usually measures improvements in symptoms based on questionnaires, rather than a medical opinion of 'cure', is almost always based on short-term interventions that have been shown (Shedler, 2018, p. 322) to fail in achieving lasting, meaningful change and the absence of follow-up data to demonstrate this, all plays into the marketisation of health delivery. This means that the cheapest offer (usually CBT-informed therapies) is bolstered by its 'evidence-based' label and there is no need to invest in a diverse workforce that might be able to manage varying levels of complexity. It also sets up other therapists, who deliver this non-evidence-based therapy, as envious and out-of-touch with the new scientific world, such that:

> it has become nearly impossible to have an intelligent discussion about what constitutes good therapy. Anyone who questions 'evidence-based' therapy risks being branded anti-evidence and anti-science. (Shedler, 2018, p. 320)

Of course the obvious answer should be that there is an appropriate place for a range of therapeutic interventions within a publicly-funded service, and the update to the NICE guidance (2019) for treating moderate to severe depression in children includes an acknowledgement of individual differences and the need for patient choice. Instead of assuming that CBT should be the first offer, it suggests talking to patients about the different therapies that might be helpful and making decisions based upon their opinion of what they feel would be best for them. This is something that Bion referred to in 1970, when he spoke about the similarities and divergences of the medical model and psychoanalysis. Much in the same way that outcomes should be defined by the patient, Bion also suggested that both the problem and treatment should be agreed by the patient, too (Bion, 1970, p. 7).

For psychoanalytic therapists, the evidence-base will frequently fall foul of the 'grade profiles' (a hierarchy of research methods was established, with case studies firmly at the bottom and Randomised Controlled Trials (RCTs) at the top) that NICE uses to evidence our practice. As Hinshelwood (2013, p. 47) explained, with the formation of NICE, 'almost without debate research became outcome research and was needed to legitimate forms of practice – and specifically to ensure the investment of government and other funders in those legitimated practices.' Some significant RCTs have been conducted (Goodyer et al., 2011; Trowell et al., 2002, 2007), but the number pales into insignificance when compared to other therapies, meaning that our own evidence is easily overlooked.

Basic assumptions and fragmented systems

The conflict, then, becomes a split between the experiential decisions on the frontline and the commissioning/policy decisions at the higher levels. Increasingly my experience, and that of psychoanalytically-trained colleagues, is that patients are offered the manualised, evidence-based therapy as a first intervention, even if colleagues offering the intervention are certain of its likely failure, and that they arrive (if they are lucky) for psychotherapy after three or four evidence-based therapies, disillusioned with the service and decidedly ambivalent about the potential effectiveness of yet another therapy. Indeed, it is a pattern replicated across services that psychoanalytic psychotherapy is often the intervention of last resort (Beedell & Payne, 1987; Kam & Midgley, 2006). Cooper and Wren question the focus upon experimental research as the main guide of mental health policy, noting that, 'RCTs may offer neither clinical generalisability nor genuine scientific advance … [because] [c]ontrolled experimental research assumes that causes are simple, and that everything except the supposed cause, and the effect of that cause, can be held constant' (2012, p. 200). They describe that the main loss in this approach to policy-making is an understanding of complexity. The 'complex' patients can be excluded from the RCTs that constitute our evidence-base for mental health in order to maintain the 'scientific' nature of research by tightly controlling variables. This results, as Cooper and Wren argue, in a deterministic model of causality, which takes little account of the psychosocial realities of a person's mental health. There is, of course, an overlap here between the medicalisation of mental health and the push for 'parity of esteem' and the use of medical-style RCTs with strict exclusion criteria to determine what therapies are considered to be 'evidence-based'. In order to meet the thresholds for a generalisable outcome, the patients involved in the trials are unlikely to be those that would likely be seen in clinical practice (Shedler, 2018, p. 323) and the higher the exclusion rates, the stronger the research outcome is (Westen & Morrison, 2001). Because of this, mental health services have developed based on a misunderstanding of a 'science' that actively excludes the increasing evidence that there are complex, social determinants of physical health (World Health Organisation, 2008) let alone mental health.

Far from creating specialist services, or 'centres of excellence' (Duffin, 2013; NHS England, 2014) with multi-disciplinary teams of complementary trainings, these changes have created a collection of units with very clear remits around their (clinical and therefore budgetary) responsibility, often in regionally consolidated and inaccessible places. Unfortunately, neither physical health, nor mental health operates in such an efficiently boundaried way, such that each health need can be treated by a single, individually-funded silo. It is very common for health problems to be interconnected; if a patient with diabetes also develops kidney disease as a result of their primary condition, there may be questions asked about whether the nephropathy is also the responsibility of the diabetes service, rather than renal service, given that one can be argued to be a result of the other. There might be local arrangements, or national guidance that supports such overlaps in commissioning for conditions with clear causality or routine progression (one in three people with diabetes will develop nephropathy (Centers for Disease Control and Prevention, 2019). However, where links are less well defined, or intervention is required to establish causation, service provision may be delayed or less certain.

Additionally, since 'core' community mental health (CMHT) and child and adolescent mental health services (CAMHS) are often commissioned separately from the neurodevelopmental service, only 'assessment and signposting' is offered to neurodivergent patients in many NHS Trusts, unless there are co-morbid mental health problems that are *overtly unrelated* to the ADHD or ASD diagnosis. Phrases such as, 'difficulties can be understood in the context of their neurodevelopmental condition,' allow managers to confidently advocate for their clinicians to deny an intervention for such patients, as they are not commissioned to offer this support; it is not within their remit. Similar problems arise where crisis services are commissioned separately; where is the boundary between crisis and not-crisis, and what happens if there are threshold gaps between the two? Narratives already exist around children, 'having to attempt suicide' (BBC, 2018) in order to access care, but this siloed commissioning also provokes this. Ideally, children who have completed a crisis service intervention and still require ongoing support would be stepped-down to the main CAMHS team, but practically, they may still be too risky for support, especially in services that are structured in the proposed IAPT way with CBT providing the majority of the support. In these cases, children will be discharged with no support, and will either re-present to emergency services (and children's A&E presentations for mental health emergencies doubled between 2010 and 2018 (Care Quality Commission, 2018, p. 23)). Ultimately this increases costs across the NHS, contrary to the policy intentions. One solution to this ('brief psychodynamic crisis work') has been proposed by Papadima et al. (2024) acknowledging that, 'crisis work and psychotherapy often operate in silos,' and noting that, under the usual system, crises are too readily seen, 'as moments to be quickly stabilised and left behind' (2024, p. 476). They demonstrate the power of going to where the problem is, and avoiding the issues of 'treat and close', some of which still persists with an adequate step-down in the transitions between silos.

The 'silo' problem is equally true in other contexts, such as Eating Disorder (ED) services where 'disordered eating' is not what they are commissioned to work with. But when all of the therapists who have expertise in this area are often employed within the ED teams, 'core' services are likely to feel out of their depth and feel a need to push back. When such gaps in service provision appear some staff may ask, 'if we don't do it, who will?' much to the chagrin of managers who are tasked with protecting the budgets of their services. This is a good question, and all too often, under the current system, the answer is that *nobody* is commissioned to provide this service. This is a problem all too present across many community NHS mental health services where, for example, the organisational dynamics and splits between 'core' and ' separate 'specialist' services are likely a contributing factor for the lower levels of, 'provision meeting need,' within the Health Service for mental health support for children with neurodevelopmental disorders (Hood et al., 2021).

Ultimately, these commissioning arrangements lead to splits (Klein, 1946) in services and 'basic assumptions' (Bion, 1961, p. 63) about the functions of teams; both assumptions about one's own team, and about the 'other' teams, as well as the factors that support the preservation and survival of teams and colleagues within the system (Stokes, 2003). This occurs as an unconscious reflex in groups where there is not a sufficient experience of a thoughtful system around the group; a lack of containment of the group anxieties leads to unconscious acting out in this way. Organisational dynamics are then further maintained by the need to compete for budgets or wider resources, such that cooperation between services is discouraged. Undertaking work that another service is *technically* commissioned for is made even more emotionally challenging by the nature of working with, 'damaged children' (whether this be actual children in a CAMHS setting, or the emotionally compromised inner-child of adult mental health patients) and the inevitability of uncontained anxieties around inadequacy (Mawson, 2003, p. 70).

Chuard has recently described how these dynamics can interfere with collaborative working, with particular reference to multi-disciplinary and multi-agency services, and notes how, when such teams are in basic assumptions mode, this leads to 'an increase in the distortion of the perception of [...] realities external to the group' (Chuard, 2021, p. 20). In multi-disciplinary services, such as community mental health, where there are often many teams with different core functions, there are at least two functions with which the team is tasked: first is the immediate function, which will vary dependent upon the team in question – delivery of assessment, therapeutic intervention, or crisis services; second the broader (shared by all teams) function of the service, which is effective, quality and timely treatment for the patient. Teams able to hold a 'work group' function hold both of these in mind and cooperation between teams is possible with little effort. But when teams are not effectively supported, and primitive anxieties take hold at individual, and then group levels, it becomes far less possible to maintain work group functioning and basic assumptions take hold.

Good examples of this can often be seen in the CAMHS settings, where many teams operate with their own funding and treatment thresholds. While the specifics of individual standard operating procedures will vary, many crisis services (for example) operate on a model of initial contact and risk assessment, followed by a second contact between three and seven days later where a further risk assessment is completed, a clinical formulation is likely to be undertaken and any existing care plan is reviewed. The work-group awareness of the shared function can be lost or rejected, and the focus on the primary function of the team, and the team's own survival, can become a rigid structure that provides reassurance, but often poor services for patients. Real cooperation with any already involved clinicians is actively discouraged in this model of care; there may be conversations with therapists, but the assessments and care planning are completed by the crisis clinician. This blinding focus can be further maintained in a conscious way, by managers who are too often concerned with budgets, but also unconsciously when management and supervision are not felt to be containing enough for the team to function freely. When this goes wrong, as can so easily be the case, the fallout can be of varying levels of impact. At its least problematic, children may be told that they could have an undiagnosed neurodevelopmental condition, and be referred for an assessment that has no impact on ongoing care, but at its worst can undermine in-progress and effective treatment. I have heard from more than one child psychotherapist of cases where a patient has been reviewed 'in crisis' and advised that they were in the wrong kind of therapy.

The organisational splits caused by 'specialist' commissioning, and the intra-service splits, thus present two vectors for the avoidance of anxiety, and through projective identification (Klein, 1959) the sense of inadequacy is easily disposed of, and located within the 'other'. It is therefore either the 'management' (including commissioners) who do not understand the needs of service users, or other colleagues who are not doing 'real' clinical work (in all projective directions) with the most needy of patients, leaving services rent with conflict and struggling to function at a basic level. This position is supported by the results of the 2022 NHS Staff Survey, which showed that for frequently patient-facing mental health clinicians, more than half reported that there were inadequate staff in the service to do the job properly, over 45% said that work relationships were, 'strained,' and while more than half of clinicians said that they undertook unpaid overtime, 14% worked almost (or more than) a whole extra day unpaid.

While the implementation of the 2012 Act sought to bring 'private-sector-style competition' to the tendering for services, in an attempt to (*prima facie*) improve outcomes and lower costs, it actually promotes paranoid-schizoid competition between clinicians within under-resourced teams and between separately commissioned teams within a single service/trust. It could be said that this is a situation by design since, as Clive Peedell (2011) points out, Section 9 of the Act removed the requirement for the NHS, or third/private sector tenders to provide *comprehensive* healthcare, instead calling only for the provision of 'such services or facilities as it considers appropriate', a phrase that has also been translated, verbatim, into the Health and Care Act (2022) under the responsibilities of the new Integrated Care Boards (ICBs) which replaced the CCGs as funders and strategic decision-makers for public health services. This then risks the provocation of a further split, both in the eyes of the public, and the employees of the Health Service, between the 'good' overworked, under-resourced and underappreciated staff, and the 'bad' legislature; a split that can flip very quickly when politicians set up striking workers (Dickson & Webber, 2022) to become the 'bad', risking contagion of the denigration to the NHS itself. This then becomes compounded when evidence also supports the position that quality of care has deteriorated in this time, as well. A recent report by the King's Fund reports that, while access to mental health services *has* improved since 2008, which was the intention of the IAPT policy, patient experience has deteriorated overall since this time, with a '*significant* deterioration in quality of care between 2018 and 2022' and that timeliness of access is also below the desired standard (Gilburt & Mallorie, 2024).

However, returning to Mawson's assertion that it is 'inevitable' that anxieties of one's own inadequacy are what lead to projective identification in such pressured health services, it should cause no surprise that it is also this anxiety provoking such projective aggression (potentially in both the context of projective identification of one's own aggression in the other, and projecting *into* the other, such that they act out real aggression) towards the NHS and sets up similar projections to occur between professional colleagues. Frequent examples are seen of media reports, or politicians making statements as if the NHS were a conscious, autonomous living thing, making it ripe for such projections, even in normal times. Thus, falling into the traps of this paranoid anxiety, other clinicians also become classified as ignorant, unthinking or as empire-building rather than cooperative, and they do the same in return.

The Darzi report

On the 18th September 2024, Lord Darzi published the 'Independent Investigation of the NHS in England.' Many of the criticisms that he had for the NHS were of Government policy, rather than of systemic staffing or productivity. The executive summary was a bullet-point list of the findings; a number of these follow the themes discussed in this paper so far. Specifically, summary point 21 reads: 'The Health and Social Care Act of 2012 was a calamity without international precedent. It proved disastrous. By dissolving the NHS management line, it took a "scorched earth" approach to health reform, the effects of which are still felt to this day' (Darzi, 2024).

Lord Darzi also claimed that, as a result of the Health and Social Care Act and the decade of austerity (both indirect and direct impacts – point 15) that preceded the COVID-19 pandemic, one major outcome of Covid was an increasingly disengaged workforce. Beyond this, it has also been argued that the NHS-as-a-business model brought about by the 2012 Act made many of the difficulties that existed pre-Covid even worse, since the Government prioritised a 'neoliberal version of economic wellbeing, over arguments about population wellbeing' (Speed & McLaren, 2022, p. 591) and as a result the NHS was 'left hugely unprepared for the Covid pandemic' (Trades Union Congress [TUC], 2023). Despite these systemic fractures, the low morale and drive for the NHS to survive, rather than live and thrive, Lord Darzi suggests that NHS staff should be at the forefront of its recovery: 'NHS staff are profoundly passionate and motivated to raise the quality of care for patients. Their talents must be harnessed to make positive change.' point 26 (Darzi, 2024).

Thinking like psychotherapists

Many have argued that the 2012 Act (and subsequent 2022 Act) was an act of slow-burn, stealth privatisation of our health sector (Mann, 2022; Puntis, 2021; Reynolds, 2013). Writing on the 'inevitability' of further privatisation of the NHS, Peedell quotes the former Health Secretary, Andrew Lansley, who constructed the Health and Social Care Act (2012) as commenting that '"maximising competition is the first guiding principle" of the reforms' (Peedell, 2011, p. d2997). Nick Mann (2022) also refers to Lansley's 2005 comments that the Act would be based upon the privatisation of former public utilities. So if this is the case, what can be done to a system that is intended to fracture, such that (cynically, one could suggest) private companies can provide high-margin, low-cost IAPT services with strong 'outcomes', regardless of whether these are the outcomes patients are interested in? Bion (1959, 1962) described 'K' as a 'thinking' state of mind, where understanding is sought and '−K' as an act of distortion; an unthinking state of mind where understanding is actively rejected. This situation, therefore, is a perfect example of attacks on linking within the system and is -K *masquerading* as K, and using this -K position to ultimately replace publicly-run services that treat complexity and that struggle with the anxiety of inadequacy in the face of vulnerable, often risky, patients. When a single American, for-profit, company already treats over half a million NHS patients in general practice (Iacobucci, 2021) and Priory Group has a partnership with at least one community CAMHS as well as being the, ‘largest provider of child and adolescent inpatient services to the NHS’ (Priory Group, 2005, 2023) it may feel like the fight is over and our demise is inevitable. Thus, psychoanalysis within the NHS seems to face the impossible choice between an apathetic march towards (comparative) professional irrelevance and our own (multidisciplinary) professional growth but overlooking the governmental attack on complexity and the ‘creeping genericism’ (Rees, 2004) of mental health services, which might still lead to our collective demise. In her response to Andrew Briggs’ paper, Teresa Bailey suggests that ‘the consultant child psychotherapist needs to set up and maintain a psychotherapy service where there is no “master/servant” relationship towards the trust/organisation, where the employees feel enslaved and devoid of agency and power […] in order to avoid sibling envy and a rivalrous dynamic’ (Bailey, 2018, p. 183). But the streamlining of mental health services often means that a team’s only consultant is a psychiatrist, or if they are lucky, a clinical psychologist (in the aftermath of the 2012 Act, this ‘scorched earth’ approach meant a reduction in senior clinical roles as well as management, forcing consultant psychotherapists to compete with consultant psychologists for a vastly decreased number of consultant roles) so the risk of this rivalry remains very real, intensified by those pre-existing feelings of no longer being the favoured ones (and perhaps the envy now directed at those who are).

While psychoanalytic colleagues may often offer the reassurance that there will always be a place for psychotherapy within the public sector, even if not within the NHS, there are already high barriers in most services for patients requiring psychotherapy, with reports of children seeing an average of 3.7 clinicians before seeing a psychotherapist (Kam & Midgley, 2006). If this is the case in current mental heath teams, then these barriers would be even greater if psychoanalytic psychotherapy was only available as an NHS-adjacent service; not something to relish as a supposedly hopeful outcome.

Despite a psychoanalytic training, the pressures of working within the NHS can still provoke paranoid-schizoid splits within psychotherapists, easily slipping into hopelessness when things feel so difficult, when systems actively discourage cooperation and promote unhelpful competition between professions for their own survival. Holding a grievance against the system or the corporate ‘parents’ is tempting, but only serves to antagonise the system and stifle our therapeutic creativity. So, letting the abusive ‘parent’ (perceived as the Government, commissioners, and service managers) off the hook seems like the only option until circumstances force a structural change within the public mental health arena. More likely, however, is a preference for the grievance and an acting out by the group.

Through this lens, the systemic/corporate dynamics can also be seen as Oedipal in nature; there is an identification with a loved parent in the function of the system (the UK NHS staff opinion surveys often show high scores for pride in and satisfaction with the NHS) (Department of Health, 2019) as well as an envied rival in the figure of the corporate/managerial ‘daddy’. The ‘gang’ state of mind has been suggested to be, ‘centrally determined by the results of the working through of the Oedipus complex’ (Canham, 2002, p. 125) in individuals, so it can be of little surprise that there are parallels in group/organisational settings as well. As such, much of what Steiner (1996) says about grievance and resentment within the Oedipal situation is equally applicable in the public health setting as it is within the therapeutic frame. This is, however, ‘a persecutory version of the attempt to resolve the Oedipus conflict’ (1996, p. 436) and when Steiner describes how, as therapists, ‘we have come to understand how [grievances] can appear to be held on to at all cost and how the analyst may be experienced as a threat, trying to take something precious away from the patient’ (1996, p. 433), this description can be seen as equally appropriate in many community mental health teams. In this scenario, the ‘therapist’ described by Steiner is all members of staff who might attempt to continue ‘thinking’ rather than colluding with the phantasy, and acting out, of attacks by and towards the commissioning/ management structure. In this persecutory version of the Oedipal struggle, the structural ‘parent’ and staff can engage in a ‘cycle of hurt and revenge’ in which grievance ‘forms the focus of a psychic retreat’ and, unfortunately, the end result is often that ‘a powerful impasse is produced where development is obstructed’ (1996, pp. 433–434). Whilst the unconscious desire is to focus psychic energy towards this righteous cycle, the conscious narrative is that the staff wish to break the impasse and work in favour of service development and meeting the timely needs of patients, in turn providing a bolstered sense of righteousness to the grievance.

Discussion

This pattern of oedipally-driven grievance is likely a familiar one to most experienced psychoanalytic psychotherapists who would readily recognise patients, abused or neglected as children, and finding themselves in an impasse in the therapy and with a narrative of grievance towards the abusing parent(s). These patients often expend great energy outside of the therapy engaging in often masochistic behaviours designed, unconsciously, to create the impasse that obstructs growth and development. Certainly my own experience is that there often comes a time in the therapy where these patients are able to consciously describe the dilemma of breaking out of this impasse as one linked to letting the abuser ‘off the hook’ and abandoning the grievance, which is felt to be intolerable. The comfort in this state comes from what Joseph (1981) has referred to as ‘psychic equilibrium’ and is resolved only after an often long and painstaking process of ‘working through’ (Freud, 1914b) and making the grievance less important; creating a space where a different kind of parental object could be internalised. This new internal object is one that doesn’t compete, split or denigrate, but sees them as deserving of both internal and external nourishment. This supports their growth and development beyond the righteous grievance and towards psychic change.

In this light, the responsibility of psychoanalytic psychotherapists is to also ignore the feelings provoked by the rival parent who, in their own enactment, projects their own inadequacy into the workforce and accuses us of ingratitude or calls us lazy, greedy or dangerous (Lister & Geissler, 2022; Schofiled, 2023) if this workforce asks to be adequately paid, for teams to be adequately staffed or to be adequately supported in doing their jobs. Instead of feeling provoked and competing with colleagues, the task is to *become* the ‘parental couple’ (the combination of both maternal and paternal functions in a reflexive and thoughtful balance,) for both our patients and the service. The anger towards the parent who will not accept their faults, and projects them on to us is a distraction from the more important task; it does not mean the disavowal of knowledge that further change is coming, or that those responsible cannot be viewed with contempt. As one example, payment-by-results has been discussed as a likely commissioning structure in mental health for some time. If such a change were to be (as is likely) imposed top-down, with either ICBs or service managers deciding what constitute ‘results’ in an IAPT-type model where service-wide use of routine outcome measures determine if treatment is effective (as opposed to patient or clinician reports) this would be a contemptible change. However, if psychoanalytic psychotherapists don’t engage in such service-level transformation as thoughtfully as can be, and with the current processes as they are, their potential demise will only be hastened. Emanuel et al. (2014) have described one way of engaging with the outcome monitoring in a way that maintains some psychoanalytic position with regards to outcomes of therapy, holding a clinical position and reference to the frame of psychoanalysis to offer meaning to changes in rating scores. This is a position also promoted by others in the field, who suggest that child psychotherapists ‘choose our fights, [and] choose our weapons’ by leveraging the structures of the system in their own defence (Bailey, 2018, p. 185). There will also be a great need to better represent ourselves as ‘evidence-based’ therapists – at the time of writing, psychoanalytic psychotherapy exists in the NICE guidelines for only two specific presentations in children: severe depression in children aged 5–11 or in adolescents where CBT has either been ineffective, or would be inappropriate (National Institute for Health and Care Excellence [NICE], 2019) and short-term psychoanalytic psychotherapy for girls, ‘showing emotional or behavioural disturbance,’ following sexual abuse (NICE, 2017). As more NHS Trusts become ‘teaching’ or ‘university’ trusts, opportunities to engage in research to demonstrate our effectiveness will be increased and with far fewer barriers.

Engagement with corporate processes is also important to supporting intra-team cohesion; psychoanalytic therapists are often perceived as being aloof, and arrogant, something Bion noted, in reflection of the psychoanalytical tendency to pursue, ‘truth at all costs’ (Bion, 1958). There is, in this, a risk of acting out and opening the profession to attack, either from those who are envious of its awareness of complexity, or those who feel attacked themselves by perceived arrogance (Freud, 1914a, p. 43). In leveraging the awareness of complexity, and a curiosity about the unknown within a multi-disciplinary team, and supporting colleagues to think collaboratively about systems and about their patients, in amenable circumstances psychoanalytic psychotherapists can offer containment to the team and by engaging with outcomes, stepping down from the supposed ivory towers and joining with colleagues for the more important task. This can be a daunting position, and one that Dawson and Ellis acknowledge, noting what prevents psychoanalytic psychotherapists from such ‘leadership’. They describe, among other things, a reluctance to give ‘oneself permission to be a leader’ perhaps linked both to another barrier they describe; the awareness of ‘excessive projections directed at those in leadership professions’ (Dawson & Ellis, 2024,

p. 15) and the perception of (or real) arrogance associated with psychoanalytic psychotherapy. Despite this, there are ways to manage associated with formal leadership as well as 'taking the lead' in a more grassroots kind of way. Psychoanalytic theory, combined with the personal analysis associated with training should provide ways in which it becomes possible to step back from the projections and envy, while maintaining an awareness of the pathological ways in which systems, especially the NHS, can behave, and support colleagues, both in the psychotherapy team and the wider MDT. It can be more easily acknowledged that with envy comes an ambivalence towards the 'favoured' role and that, even when 'the system' might not want to acknowledge complexity and the need for a nuanced approach to mental health (because this also challenges the outcome-focussed, easily measured KPI-driven structure), colleagues and peers often rely heavily on this ability to step back and think, when it is offered without demand or expectation.

Note

1. Freud later elaborated on his existing use of the term 'disavowal' and detailed the difference between repression of affect, and the disavowal (as in this instance) of a whole thought/idea, in his paper on Fetishism (1927).

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Patient anonymisation statement

Potentially personally identifying information presented in this article that relates directly or indirectly to an individual, or individuals, has been changed to disguise and safeguard the confidentiality, privacy and data protection rights of those concerned, in accordance with the journal's anonymisation policy.

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