

Correspondence

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Continuity of care: under attack

I read with great interest the interpretations offered in the study by Macdonald *et al.*¹ In trying to understand links between lack of continuity of care in the community and poor outcomes for patients with schizophrenia, the authors wonder whether a 'disrespect of continuity' manifest in repeated organisational change somehow translates into everyday clinical situations. For me, it is not a reassuring discovery that here is hard evidence for what we as clinicians have always suspected: that repeated organisational change seems driven neither by the best interests of the patient nor an economic imperative. The study beautifully highlights the important idea that what is really being attacked here is continuity.

But why attack continuity? Because of the obvious reason, of course – it is easier to attack it than to offer it. It is easier to create newer, smaller teams and splice the patient temporally into acute versus chronic/early versus long term/compliant versus non-compliant/risky versus not risky, rather than to bear that these are all aspects of the same patient and may need to stay in the same place as opposed to being scattered to the four winds!

The great British psychoanalyst Wilfrid Bion² writes about his struggles in trying to treat a patient who is psychotic who experiences him as obstructive and unhelpful. Bion is troubled; and takes this up seriously. He then explains that he discovered he had been trying to impose his own language on the patient, rather than trying to bear the patient's language of projective identification. Bion's realisation led to a breakthrough. Thus, for coining one of the most popular terms in psychiatric services today – 'containment', we owe a debt to him.³ It goes without saying that the need for their anxieties and fears to be contained is something all patients bring to us, and as an example of a serious mental illness, psychosis requires skilful intervention on the part of services.

Schizophrenia is an illness rubric that brings together people with many vulnerabilities, but all with a common theme:⁴ patients whose minds struggle to integrate conflicting feelings and thoughts safely, leaving themselves and others connected to them at an ever-present risk of alienation. The harmful effects of failings in continuity are well documented.⁵ The chilling conclusions of this study also highlights declining outcomes linked to poor continuity, independent of service reorganisation. It raises the obvious question: does 'poor continuity' also mean that staff become cut-off from the patient in a cut-off state of mind?

Returning to Bion, what changes his practice is his interest in and concern for his patient. If an organisation, claiming to care, conveys 'disrespect' as the authors astutely point out, what state of mind does the clinician find themselves in? It is difficult to manage and treat seriously ill patients, and it cannot be done safely by staff who feel alienated all the time, from their own team and from the organisation.⁶ The authors suggest a more sober approach in the future towards casual change; I think there needs to also be a closer look at the nature and function of organisational attacks on good clinical care in the name of change.

- 1 Macdonald A, Adamis D, Craig T, Murray R. Continuity of care and clinical outcomes in the community for people with severe mental illness. *Br J Psychiatry* 2019; **214**: 273–8.
- 2 Bion WR. On arrogance. *Int J Psycho-Anal* 1958; **39**: 144–6.
- 3 Bion, WR. *Learning from Experience*. Tavistock, 1962.
- 4 Postmes L, Sno HN, Goedhart S, van der Stel J, Heering HD, de Haan L. Schizophrenia as a self-disorder due to perceptual incoherence. *Schizophr Res* 2014; **152**: 41–50.
- 5 Sanatinia R, Cowan V, Barnicot K, Zalewska K, Shiers D, Cooper S, et al. Loss of relational continuity of care in schizophrenia: associations with patient satisfaction and quality of care. *BJPsych Open* 2016; **2**: 318–22.
- 6 Menon A, Flannigan C, Tacchi M, Johnston J. Burnout – or heartburn? A psychoanalytic view on staff burnout in the context of service transformation in a crisis service in Leeds. *Psychoanal Psychother* 2015; **29**: 330–42.

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Author's reply

We thank Dr Menon for her appreciation of our study, particularly the evidence we give of the twin threats to good patient outcomes: constant reorganisation of services and independently, within the resulting ephemeral 'teams', declining continuity of care for this very vulnerable group.¹ It seems to us likely that, as she says, burnout is responsible for the latter. It seems unlikely that our findings only relate to one particular National Health Service (NHS) trust. The local response to our work – in the Trust and among commissioners – has been handwringing. So, what is to be done? We suggest the following.

(a) Let everybody in the NHS – from top to bottom – use honest language. The title of Dr Menon and her colleagues' own work on this topic² contains the latest of a long list of Orwellian words – 'transformation'. If we are instituting or participating in a reorganisation that is primarily stimulated by (if not likely to accommodate) declining resources, let us all say so. If we cannot bear to use the C word, let us call reorganisation 'retrenchment', 'strategic withdrawal' or some such, and not pretend that it is a great leap forward.

(b) Let everybody in the NHS – from top to bottom – acknowledge Dr Menon's point that relationship continuity of care is at the heart of what we do. It is time that it is routinely measured and monitored, especially during reorganisation, whatever the stimulus for this.

(c) Let everybody in the NHS – from top to bottom – stop paying lip service to routine clinical outcomes measurement and devote resources to it. In this way the impact of interventions at every level – from patient treatment to reorganisation – can be monitored so they can be modified.

- 1 Macdonald A, Adamis D, Craig T, Murray R. Continuity of care and clinical outcomes in the community for people with severe mental illness. *Br J Psychiatry* 2019; **214**: 273–8.
- 2 Menon A, Flannigan C, Tacchi M and Johnston J. Burnout-or heartburn? A psychoanalytic view on staff burnout in the context of service transformation in a crisis service in Leeds. *Psychoanal Psychother* 2015; **29**: 330–42.

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