OUR LEARNING ABOUT MECHANISTIC AND RELATIONAL SYSTEMS

Origins of Living Well

The Living Well UK programme has its origins in Lambeth, south east London, where, in 2010, a 'Collaborative' of people who use services, carers, NHS commissioners, Lambeth Council, voluntary and community sector, secondary care and primary care came together to try to 'turn the system on its head', by moving energy and resource from secondary care to primary and community settings, and in this way provide preventative, person centred and holistic support for working age adults who were struggling with their mental health.

Innovation Unit supported Lambeth's Collaborative to co-design and prototype its Living Well Network Hub, a model of multidisciplinary team working that combined the best of clinical, voluntary sector and peer worker skill and experience to give help where and when it was needed. The Hub went live across the whole borough in 2015. Soon after, the model was supporting upwards of 6,000 per year, and successive independent evaluations showed significant positive impacts for mental health outcomes, delivery costs and staff morale.[1]

In 2017 we supported Lambeth to evolve the Living Well Network Hub model into what became Living well Centres, which integrated with Community Mental Health Teams. Lambeth's Living Well Centre model predates and embodies much of the vision described in NHSE's Community Mental Health Framework for Adults and Older Adults (2019).

Technical failure?

Back in 2018, the promise of Lambeth Living Well for stakeholders in our four sites was a chance to fill a well-known gap in commissioned mental health service provision; namely, a large group of working age adults who tended to 'bounce around' the system without getting their needs met because they were seen as 'too complex' for primary care and 'not unwell enough' for secondary care. Typically, these people had: a mental health diagnosis, complex psychological and social needs, experienced trauma, a history of family and maternal mental ill health, caring responsibilities, transitioned from young people's services, and long-term physical health conditions.

At that time, leaders in our sites may have thought they were simply responding to a technical or managerial failure of commissioning. In other words, up until then they had not commissioned a service for this group, but after Living Well, they had.

1 https://www.lambethcollaborative.org.uk/13943

Stuck systems

But what we (our sites and Innovation Unit) can now see, is that the failure to meet the needs of this group was not just a technical failure to plan for and deliver support to people in need. It was also an expression of something quite different, quite profound, and something which is critical to our understanding of why our UK mental health systems are so stuck.

The mantra of 'too complex' for primary and 'not unwell enough' for secondary care was - and still is - one articulation of mental health systems all over the UK that have for too long been dominated by what we call a 'mechanistic' response to mental health.

The choice of the mechanistic response

It is clear for us to see that the current, dominant, UK response to mental health is mechanistic. The mechanistic response has contributed to many of our system problems that NHS England's Community Mental Health Framework was brought in to address, including fragmentation, inequity of access and support for some, a failure to collaborate across teams, organisations and sectors, and the lack of timely, person-centred and holistic care and support.

But the Framework's call for radically transformed outcomes for people experiencing mental distress - and indeed any kind of genuine transformation towards much better outcomes for people - will not be realised unless we recognise the dominance of the mechanistic response, accept that this response is a choice (it is not natural or unavoidable), and deepen our capacity for a more relational response.

The mechanistic response is founded on a way of thinking that people's mental health needs are finite and can be categorised (through ever-expanding diagnosis). It understands mental health as something that needs to be managed (for example with thresholds and eligibility criteria), contained (for example by putting people in secure units under Section), controlled (for example with drugs), and treated (for example with six sessions of CBT). The mechanistic response is supported by the biomedical model, in which the mechanisms of neurotransmitters in the brain can become faulty. The cultural power and status of medical expertise (particularly psychiatry, in mental health), has been cemented over the twentieth and twenty-first centuries and has reinforced society's acceptance of the idea that the most 'complex' expressions of mental health distress can and must only be managed by this mechanistic response, and only by our clinicians.

This dominant way of thinking is embodied in our mental health systems, most obviously in the formal, statutory system, where our clinicians control access to NICE-approved, standardised clinical services and pathways that are only available to defined

population groups with rigid characteristics. Getting into, moving through, and leaving ('discharging' from) our services is managed by the same logic used in the factory assembly line, with a linear and formulaic process using strict criteria relating to need, complexity, diagnosis, prognosis and evaluation of patients' progress. The aim is to maintain quality and efficiency through a standardised and repeatable process.

Like a machine, our practitioners are asked to be cogs playing a narrow and defined role. They work for organisations, not the wider system. Much of their time and effort is spent managing demand, flow and risk in the context of a limited view of available resources, most of which are commissioned as NHS clinical expertise and provision, with resources from our voluntary sector organisations and our communities filling gaps and extending reach. In the mechanistic model, when gaps or failings in support are identified, more resources are added, services are adjusted, or resources (including staff and teams) are moved or rearranged.

In the mechanistic system, we seek to improve services through gradual, piece-meal improvement and development. Managers focus on quality improvement, both as a means to incrementally improve what is already there, and as a response to failing or underperforming services. We have seen this lead to important improvements in the quality and efficiency of the separate parts of our services and treatments. However, these developments are often delivered and assessed in isolation from one another and without an assessment of the overall impact on people's lives. This is because in this approach to improvement, the underlying logic or beliefs that our services embody (for example asking people with very different needs to accept standardised offers and pathways, or seeing people as full of deficit and risk, not capacity and agency), are not examined. The result is that service failings are reinforced and transferred in new developments.

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Critics, including our leading national charities and prestigious clinical bodies, lay the blame squarely on decades of government failure to adequately plan for and invest in growth of formal NHS services, in particular more clinicians and more hospital beds.

There is no doubt that more support is needed, and that part of the solution lies in growing our public sector workforce and estate. And it's also true that there are many intersecting factors that account for the poor state of our collective mental health (including of course impacts of the recent Covid 19 pandemic).

But what holds us back most of all, we argue, is the dominance of our mechanistic response to mental health and the way that it stops us developing new and better responses.

In particular, the way in which our mental health system (NHS and other services) creates barriers, processes and structures that serve practically and emotionally to separate those working in the system from the distress of those seeking help. There are at least two kinds of understandable overwhelm:

- The overwhelm associated with increasing demand that simply cannot be met by formal services within available financial resources. In the mechanistic response, our systems cope by deploying eligibility criteria, high thresholds and waiting lists, and by attempting to shift demand from one part of the system to another (for example from secondary to primary care), despite knowing that the entire system is overstretched.
- The overwhelm associated with the emotional difficulty of 'holding' and 'being with' the whole person in their full distress, and the worry of not being able to 'manage' risk. In the mechanistic response, our systems cope by developing specialist roles that only work with part of a person's need (their clinical need), rather than see and help the whole person, in all their complexity. This often means declining to offer any help at all ("come back when you've addressed your substance misuse issues"), and asking people to access multiple specialists working separately across different parts of the system.

A whole bureaucracy is then created that forces staff to spend more time assessing and managing than actually providing care and support. But this effort is ineffective in the face of rising demand and complexity, and the result is frustrated citizens and staff burnout.

We can't carry on with mechanistic systems that cannot relate fully to distress. Look at what this is doing to the workforce (recent surveys show that almost half of our NHS workforce go to work despite not feeling well enough to perform their duties because of stress[2]), to people waiting for help, and to families and friends who feel helpless to know how to respond in the meantime.

These responses will never be enough to tackle our mental health crisis.

2 https://committees.parliament.uk/publications/6158/documents/68766/default/ (p.9)

National ‘transformation’ programmes, such as the 2019 Framework (coordinated centrally by the NHS and tending to appear every few decades), struggle to unlock imagination, human potential and real change. This is because they come up against deeply ingrained mechanistic ways of organising people and resources that exert a powerful influence on practitioners and that appear to them to be the best and most logical response to a context of overwhelming demand.

For example, the language of ‘referring’ someone (rather than ‘warmly introducing’) is proving remarkably durable, as is the perception that voluntary sector workers are not as trustworthy when managing risk compared to their clinical colleagues. Many of the new multidisciplinary teams across England set up to realise the Framework have found it hard to overcome professional silos, and the primacy of clinical assessment tools remains. Place-based transformation programmes have in most cases successfully reconfigured and reengineered teams and services, but the deeper assumptions, values and beliefs which give life, energy and shape to the systems themselves have largely gone unchallenged.

But it’s not true to say that the choice is between mechanistic or relational responses. There will be times, for example, when practitioners will absolutely need to ‘focus on their part’ and be accountable to their individual role and organisation. And the reality is that all mental health systems in the UK will have both mechanistic and relational characteristics.

By contrast, the task is to value both responses. For example, to have the best chance of significantly improving outcomes for people, we need to both value solutions that already have an evidence base, and co-produce new responses that draw on diverse wisdom. We can enquire into why existing evidence-based solutions are working for some people, and use that insight as one input into work to co-produce something new and even better. Or, a powerful way of being accountable to our organisations is to be responsible for and stay in relation to the whole system; we can connect to wider resources and use them to better meet people’s needs and therefore better fulfil our organisation’s mission.

The starting point is to recognise the dominance of mechanistic responses, and to start to collectively explore how practitioners in local systems might start to realise the untapped possibilities offered by more relational responses.