

The Future of Therapy

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This selection of blogs about working in mental health were written as part of www.survivingwork.org over a period of five years. The blogs started in 2012 when I was training and working as an honorary therapist in the NHS and continued over the last five years of researching into working in healthcare. Some were reproduced in the magazines of the professional bodies and some for theconversation.com and the LSE's Politics & Policy and Business Review blogs.

In 2016 I carried out the Surviving Work Survey looking at the working conditions of therapists, defined broadly in mental health services. A summary of the 1500 responses and 68 interviews is presented at www.thefutureoftherapy.org to stimulate debate and thinking about the sector. Over 2017-2018 I am writing a series of academic articles about key themes; performance management and terror of targets; self-employment and the myth of private practice; the growth of unwaged work through training bodies and the third sector; IAPT and the link to welfare reform.

Peer reviewed publications are important to build an informed and credible debate about the future of the mental health workforce, but it takes a long time so this eBook is an introduction to the issues at play. Some of these blogs look at the specific industrial relations issues for therapists, some the systemic factors affecting how they work. All of them attempt to convey the fear and loathing, loving and hating involved in this extraordinary field of work.

What follows is a pretty bleak picture of what its like to work in mental health and a some guidance on how to survive it. On the website www.thefutureoftherapy.org we encourage you to set up a Survival Surgery where you work. Whether you call it solidarity or social capital, the bottom line for our survival is to build our capacities for forming good-enough relationships at work.

In the last chapter we outline how you could hold a Survival Surgery in your workplace - a model based on trade union education methods that can open up better team working in healthcare settings.

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The Surviving Work Survey

Despite our national preoccupation with mental health, the absence of debate about the people delivering those services is strikingly absent. The confusion and ignorance about the employment relations systems in mental health is very much about the continuous privatization and restructuring of the NHS, and partly explains the lack of awareness about the range of employment relations problems faced by mental health workers.

After years of talking to working people about their lives I can honestly say that therapists are the least likely to talk about their working lives. The profound irony that we aren't talking to each other is matched by a further irony that by not looking at growth of precarious work in mental health services we're in denial about the realities of therapeutic work. There is an obvious causal link between this professional denial and silence and the stark lack of strategy of our professional structures about the future of therapy. Add to this the still-prevalent 'NoasArkism' that exists where some of us think we still have a place on the professional boat and as it stands we're not well organised to address the crisis of jobs and wages ahead.

In 2016 the Surviving Work Survey was carried out to try to get a sense of what is happening in the therapeutic professions and ask some blunt questions about pay, promotion prospects and the decline in decent jobs. 1500 of you filled completed the 50 (!) questions about working conditions and 70 of you were interviewed. The results of the survey are summarised on www.thefutureofwork.org and over the next two years we will be publishing a series of academic articles picking up on four key themes: IAPT & Welfare; Honoraries and the link to the therapeutic training and professional bodies; The growth of self-employment and the myth of the therapeutic entrepreneur; Performance management and the tyranny of targets. The issues they raise are summarised in this eBook in part because the academic publishing process will take several years and we want to raise awareness of the workforce issues ahead.

The Key Results

It's no wonder nobody seems to know anything about therapeutic jobs because its a complex picture. Although 74% said they worked for the NHS, 54% are working in multiple settings, many are on short term contracts or hourly paid, running from one job to the next.

When we started the research, we had dreamed of producing a glorious regional map of specific characteristics, but apart from one third of the highest level jobs being in London, there were no significant variations in the work, pay and experiences of therapists in the

UK. Instead, the key findings present a bleak prognosis for earning a living as a therapist.

How much?

It's unavoidable to point out that many therapists aren't earning enough. A staggering 18% of respondents earn less than £300 per week, with an average income of £401-500 after tax. This is partly explained by one third of people working part time - with most people we interviewed saying that this was their primary way to cope with the increased distress and pressure at work - but the problem of income also relates to two key trends; the growth of unwaged work and self-employment.

Our survey shows that 21% of therapists work unwaged as honoraries but interestingly only 15% were trainees, with 6% representing an emerging group of mainly senior clinicians working for free - most working in the Third Sector and the NHS towards the end of their careers, presumably funded by the remaining NHS pension fund. The NHS and the Third Sector are quietly sustaining many services on unwaged work with 15% of honoraries estimating a loss of income of over £401 per week. It's worth pointing out that as our professional bodies require clinical hours for training and professional registration we have the curious situation that the bodies charged with protecting the profession are undermining it if the future therapeutic workforce will need to be people only from affluent backgrounds.

Self-Employment

Connected to this is the growth of self-employment in the public sector, a much misunderstood category of work in the UK. Just under 20% of therapists are self-employed - but with 91% working in multiple settings and only 6% of self-employed representing the remote fantasy of a psychoanalyst in an Afghan rugged consulting room in North London.

What the survey implies is that self-employed therapists are increasingly being used by employers to avoid social costs of direct employment. No more pensions, no more sick pay, no more CPD. This raises important questions not just about professional liability but also the duties of care of employers. Many mental health workers when asked who they work for will say the NHS - but the reality is that as self-employed clinicians there is a growing confusion over clinical and employers' responsibilities, not least in terms of who is insured for what.

Downgraded jobs

Many of the people in the survey raised concerns about the growth of mechanised and short term therapy being offered through IAPT and more generally across mental health. Many senior clinicians are walking the thin line of working responsibly and not breaking their contracts of employment, particularly in IAPT services. We know that increasingly

senior positions are not being filled above Band 8a, and as more and more people become unable to fund their own training, the NHS will face a skills deficit as people cannot afford long term psychodynamic clinical training. As the lack of secure jobs increases, this will have an even greater downward pressure on the number of people willing and able to fund long expensive trainings to enter the profession. Of all the issues that we need our professional bodies to address rather than evade, it's this one.

This internal pressure is matched by an external one where, although not yet significant, the crisis in mental health services is a major strategic opportunity for private and third sector contractors and private employment agencies who are literally buying up the growing NHS waiting lists. From our interviews, there appears to be a particular growth in private employment agencies providing IAPT services in Child and Adolescent Mental Health Services (CAMHS) as the Child and Young Persons (CYP-IAPT) services are being rolled out in England. There is also a strategic growth of 'non-clinical' jobs - from PWP's to digital CBT programmes, many of these jobs will not require clinicians to deliver them.

Poor Management & workplace relationships

Surprisingly, one issue that people raised when we asked them "what would improve your working life?" was better management. This was an open ended question, and in addition to talking about funding, the vast majority of people raised concerns about lack of accountability and management. This came out vividly in the questions about raising concerns where only 25% of patient concerns were resolved adequately and only 6% of concerns about working conditions were resolved. Unsurprisingly when issues are presented as patient safety they are taken much more seriously but the vast majority of concerns were actually about poor clinical settings and lack of staffing/qualified staff and supervision. The resounding picture is of a management who take a 'hands-tied-headless-chicken' school of management.

Two further things stood out - the low number of people who went to a trade union or directly to colleagues with their problems. For people trained to increase relationality there's a real question why we don't seem to be doing that with the people we work with. Secondly an average of 5% of people who raised concerns were victimised, many losing their jobs or facing constructive dismissal. This may not sound like much but nothing puts a downward pressure on people ever raising concerns again than seeing a colleague hit the dust. This was the saddest part of the survey for me, how little impact we're having in bringing about real changes at work.

Future Workforce Scenarios

Although many experienced therapists are successfully working in a combination of

private practice and NHS work, the demography of the sector indicates that they are only able to earn a living having spent most of their working lives in the NHS leaving their pensions and mortgages intact. As 21% of therapists are 57 years and older this generation of psychotherapists will retire within the next 5-10 years leaving behind several generations of precarious therapists who will never earn enough to cover the basics of housing and professional development.

As the private employment agencies and digital health companies mop up the NHS contracts fully aware of the workforce trajectories, the myth of the self-employed therapist as a sustainable job will become exposed. This has implications for our professional and training bodies, particularly those that are currently recruiting on the basis of a professional fiction.

The Organising Challenge

It is a growing possibility that we are within a decade of the genuinely therapeutic professions dying out. The current economic argument for mental health services is based on the unacceptable working conditions of mental health workers. From the thousands of counsellors working in IAPT to the honorary psychotherapists propping up the Third Sector, working in mental health is posing significant health risks to both clients and clinicians. As we become de-professionalised, downgraded and demoralised and our experienced leadership retired, this leaves the gates open to private providers to fill the gap going forward towards a mental health service made up of tick boxes and compulsory wellness with psychoanalysis relegated to a heritage industry.

In a context of downgraded mental health services, the fact that mental health workers are unorganised and silenced is a matter for both professional and personal ethical concern. Sometimes working in healthcare forces you to walk a very thin line between the personal and the political - an awkward place somewhere between the consulting room, Whitehall and the board room. If the entire history of improving working conditions through collective action is anything to go by this involves setting the battle lines - the principles that form the basis of care - and the conditions under which those principles can survive. It also requires us making strategic choices about where we target our energies choosing those battles that we have not already lost. It would be a good place to start to block and regulate the growing field of digital providers and private employment agencies before it is too late.

Bearing in mind that the institutions of mental health are themselves facing crisis I'm not going to suggest that there's an easy way to collectivise within our professional networks. Having worked in trade unions for much of my working life there is not one romantic bone left in my body about unions as organisations but they are the only show in town when it

comes to the hard core employment relations job of defending workers and bargaining over wages.

This is where we need to head, towards creating a platform where wages and working conditions can be negotiated with employers. It is inevitable that this will require working across organisations and networks and stepping out of our professional silos. But most importantly if you as a clinician want to change where the sector is going, you just have to join a union.

There are a growing number of political groups and networks for mental health workers - all of them worth joining with the added bonus that they have yet to be institutionalised and are, well, more fun than your average professional committee meeting. Even though it may mean leaving the house on a rainy Tuesday evening, just do it when you can.

For those of you within the professional bodies please try to stay there but be a pedant and run the risk of people sighing when you raise the issue of employment contracts yet again. If you're part of a structure that can make any difference to the downgrading of services please try to stay within them. We need you more than we ever say.

Although we all struggle with the desire to manage work from under a duvet, to organise a response to the downgrading of services will require us freely associating with as many people as we can at work. Yes, talking to the people we work with. This is a psychological war we have entered into - and part of that battle is to associate with people across our sector, even those that are different from us, and hold to different ways of working. To listen to each other and be prepared to be influenced by what we hear. To support the individuals and groups that take up true leadership and to challenge those that maintain the political Noas-Arkism that dominates our professional and training bodies.

We all have to become citizens in mental health, not just clinicians if we are to survive.

Socially Prescribed

Drunk on hope and suffering from a democratic hang over I woke up on Friday feeling profoundly lonely. Weeks of life affirming contact with other human beings was welcome confirmation that most people are way ahead of the political leadership in actually practicing their politics. Just 48 hours later and we're in sight of making concessions around human rights, a red flag that we have entered a period where our institutions are ruthlessly focussed on their own survival, not ours.

I've watched Season 5 of House of Cards, but this is like taking a bullet.

On Friday I had the self-preservation to meet [Chris](#)¹, a retired GP with a steady mind who has literally done everything in primary care that is now being described as 'innovation'. Chris is a genuine human being as well as or despite his medical training. It's through him that I have established a respect for science and an acceptance that biological determinism is not a right wing conspiracy against feminists.

As often happens when two very different people meet, we talk about stuff I've never thought of before, on this occasion the nervous system, parasympathetic systems and our reactions to stress. He heroically ignores my inability to retain whole facts while maintaining a deep respect for my capacity to think about stuff. I'll save you my failed-human-biology-GSCE description of the nervous system and skip to the point that in this conversation we talked about freezing and folding, the less well known cousins to fight and flight, and two of our automatic reactions to threat.

Although I'm not trying to excuse bad politics, this conversation helped me to process the paralysis and inward looking responses of the current healthcare 'leadership' to the very clear writing on the wall for mental health services in the UK.

The Writing on the Wall

Last week two things happened that really shook my faith in our ability to turn round the crisis in mental health.

The first was that I attended yet another conference at a well known health policy institute in London about the future of mental health in primary care. Honestly, I'm not sure why they still let people like me through the door because by inviting well meaning clinicians to talk about the roll out of the main NHS mental health programme – Increased Access to Psychological Therapies (IAPT) – all they are doing is spelling out on power point slides the government's strategy to destroy the welfare state.

¹ <http://www.nhswellbeing.org/>

In amongst the graphics on care pathways and integrated services, the corruption of mental health services to facilitate cutting benefits was exposed. I'm going to be blunt now and tell you that this new policy heralds the shift from publicly accessible mental health services to a system of psycho-compulsion designed to cut the benefits bill.

The IAPT programme has gone through several waves since its creation in 2008, introducing short term cognitive behavioural therapy and 'wellbeing' interventions into the NHS. Much has been written critically about the quality of IAPT services and conditions of the people working in it, but this hasn't stopped the roll-out of IAPT from adult to children's services and primary care. The growth of IAPT has led to the dominance of a short term and diluted model of cognitive and behavioural therapy (CBT) despite the 'evidence-base' for its effectiveness being widely challenged.

What I had not realised until last week was that the next wave of IAPT now rests on delivering services designed specifically to reduce welfare claimants. Welfare is being reformed with the introduction of the new [Work and Health Programme](#)² in Autumn 2017. This new strategy is being delivered under a partnership between the Departments of Health and Work & Pensions, and the many private sector providers operating in both sectors, designed to increase the physical and mental 'wellbeing' of claimants to get them off benefits.

This link between mental health problems and benefits is clear – we know that 50% of disability claimants are living with mental illness and that the 'problem' of mental health has an evidenced link to growing poverty and inequality in the UK. But the new Work and Health programme does not attempt to increase incomes through decent jobs because, as any honorary psychotherapist working for Mind or AgeUK will tell you, finding a job that pays a living wage is an increasingly remote possibility.

Reform will happen by partnering employment and mental health services in GP surgeries and Job Centres. This includes the introduction of employment support workers (ESWs) and wellbeing services into GP surgeries funded through the DWP while the Third Sector provides trainees and volunteers to bulk up the numbers. Additionally 'Allied Healthcare Professionals' will provide mental health services for Job Seekers Plus and the private contractors delivering 'employability' interventions for the DWP such as Reed. Much of this work will be online or using 'psycho-education' workshops to build individual psychological wellbeing.

Despite the image of a Job Seekers Plus wellbeing workshop being delivered by an unwaged trainee having the depressing feel of careers advice in the 1980s, I'm a big fan

2 <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7845%252523fullreport>

of adult education. My experience of delivering psychosocial education for the last few decades is that if you put a group of people in a room together and allow them to talk freely, good stuff can happen. This is doubly so if you have an experienced and kind facilitator.

However this wellbeing and psychoeducation 'service' involves an appropriation of participatory and therapeutic methods in an attempt to stifle non-compliance. Discussion groups and listening exercises, used to silence rather than empower because of the inherent threat of benefit sanctions and recovery targets. Although the methods might in principle be sound, they are being delivered in a context of compulsory wellness where both service users and service providers must be fit for work.

A laugh-or-cry aspect of these new wellbeing services is the use of social prescribing. This is an actual thing that is talked about with a straight face, where people are prescribed through the NHS social activities that will help their wellbeing. I don't want to be rude but there's a strange twisted feeling in getting a prescription for being social from my lost and burnt out GP. It's true that loneliness and lack of recreation is a massive problem in our society, but for most of us this is due to a lack of time, money and public services, not the absence of a prescribed social activity. I'm just not sure that the NHS is a centre of excellence for having fun.

The use of these prescriptive methods in the current mental health service is a long way from the emancipatory aims and free association on which psychotherapy is based. What is happening here is the perversion of mental health services through the industrialisation and bureaucratisation of care. The wellbeing checklists, self-guided apps, the fitness for work assessments are not some benign mistake, it is precisely through them that a psycho-compulsion is being introduced. This is not my paranoia, it's literally through the compulsory reporting of a 50% recovery rate in IAPT that people will be deemed fit for work and their benefits cut. Under this regime, people are being silenced and herded into 'voluntary' wellbeing programmes through the threat of sanctions.

This radical reform of mental health services is being slipped in under the radar because we have put people who are financially invested in maintaining this system in charge of the professional and political bodies that govern it. They have been seduced by the prospect of 3000 new mental health jobs by 2020 and the warm glow of a safe retirement in the next five years. Whether conscious or not, our current leadership have allowed us to enter a period of freezing and folding inwards rather than fighting the necessary fight to defend genuine therapy.

If the motivations of the people designing and delivering mental health services are just to keep this industrialised model of care on the road then what comes out of mental health services will be radically different from any concept of patient led care that we're familiar

with.

As is common at such events, it takes a working class service user from Nottinghamshire in the last session of the day to bring some sanity into the debate and point this out. Having patiently participated in the power points he says out loud that despite being on the left, he won't campaign for more mental health funding until the system is worth defending. He said that the best thing for his mental health was to spend time with friends for which you don't need to set up a whole industry of social prescribing delivered by third sector volunteers. You just pay people a basic income enough to make their own decisions about how they live.

Therapy in the current political climate is being used to normalise the fact that more and more people in the UK don't earn enough to live a decent and secure life. Rather than engaging in wage bargaining or progressive reform of welfare benefits, the state is using mental health services to evade their social responsibilities to establish a functioning industrial strategy.

Silencing the People on the Edges

The second thing that happened last week was that I was told that I had been blacklisted by two of the main psychotherapeutic bodies in advance of my publishing the results of the Surviving Work Survey that looks at working conditions in mental health services. Despite the recognised and chronic lack of mental health workforce data, it appears that independent research is not welcome in the ever-decreasing-circles of our professional institutions.

Despite this fact-phobia, we will inevitably see over the next year more information about the workforce crisis about to hit health and social care. Some of the reasons for this are general – that the UK is a low wage economy, the impact of Brexit, and the unsustainable costs of clinical training and professional registration. All of these factors are bad news for keeping genuine health services alive but mental health services are facing a much deeper crisis over the emergence of sub-therapy and psycho-compulsion and with it the corruption of the therapeutic field.

As someone who has a long term relationship with psychoanalysis, as a patient and a clinician, I do not in any way underestimate psychotherapy's powerful and, under the right circumstances, political framework. I believe it helped me stay alive and grow up to be an ordinary human being. I also think it has made me a better activist and more likely to bring about social change.

Although most of the people working in mental health still use this core tradition in their work, the principles and practices of psychotherapy are being perverted by the

implementation of IAPT and the Work and Health Programme.

Firstly, genuine psychotherapy increasingly is not offered in the NHS because it can't be done as cheaply as IAPT interventions. This isn't to say that the ROI of psychotherapy can't be argued – it can if you're actually interested in treating actual people with actual mental health problems. But the 'evidence base' for IAPT is based on a model of telephone assessments using scripted questionnaires where nobody can actually say how they feel, allowing assessors to refer patients to short term interventions that aren't, for example, designed to treat depression. Although increasingly real therapy isn't being delivered through IAPT, what matters to the government is that in the short term it's cheaper, particularly if its delivered by unwaged trainees provided by clinical training and professional bodies.

What may be more problematic in arguing for funding is that because psychotherapy helps people to take control of their own lives it means that the 'evidence base' for psychotherapy can't be manufactured around the demands of politically set targets. Although [research](#)³ shows that psychotherapy is highly effective in the long term, it doesn't compel people to become well in a 6 week period.

Ironically for therapists in the business of talking and thinking, the psychoanalytic professional structures are not doing that when it comes to the future of public mental health services. Although there are some extraordinary people in these systems, the prevalence of Noasarkism and the strains of managing decline has provoked both a freezing and a folding inwards. This is not principally a problem of innovation – in my experience clinicians are always having good ideas – rather a problem of professional ethics. That the bodies charged with defending psychotherapy are failing to defend the principles on which they depend.

This might explain the reluctance of the professional bodies to engage in the much needed debate about the future of mental health services with a wider audience including those critical insiders and outsiders who are researching workforce issues. Add to this the temptation to blacklist critics and you end up with a system that cannot hear different views and becomes entrenched in defending their own existence. Although this freezing and folding is understandable as a response to threat, it is about to create a split between the interests of the people providing the services and the people accessing them.

If you think I'm exaggerating, ask an IAPT worker if they would let their family use the service.

Parasympathetic

I relate all of this along with swearing and hand gestures to Chris. As often happens when

3 <https://bmcpsy psychiatry.biomedcentral.com/articles/10.1186/1471-244X-12-60>

you find yourself talking to someone who is actually listening to you, you end up learning what you believe. Out of the blue I found myself saying “I don’t know whether I believe in mental health any more”. That’s a gulp-moment for someone who has just spent the last ten years trying to build their own and other people’s.

Just as I say this tear-jerking-statement-I-never-thought-I’d-make, a familiar face comes up to our table, all glowing and smiling and invites us to an anti-war event. This beatific creature is Bruce Kent of CND. Not a day older, not a whiff of cynicism or despair, just a man secure in his beliefs. We then try to tell him how much he means to us without actually licking his face. Hope incarnate.

One of the tyrannies of witnessing the speed at which mental health services are being corrupted is that its hard to resist the urge to act. There is a battle ahead about the future of public mental health services in this country and although there’s nothing wrong with being an activist or a therapist or both, sometimes doing is a way of avoiding reality. Not wishing to get all Freudian on you, but understanding is the foundation of change.

Everyday politics is a long-game requiring enormous stamina and a good sense of humour. When something important has to be understood it requires the mind to slow down and enlist the parasympathetic system that allows the body to relax and be still. Rather than launch myself all-fists-and-teeth into the next fight or go off-grid living with wolves, I’m going to spend the summer thinking and writing about the future of mental health services from the perspective of the people delivering them. I’m going to do something that does not come naturally to me and be pedantic about my methods and measured in my analysis. I’m doing this because the facts need to be delivered in a way that demand they be heard rather than dismissed as the rant of an angry insider/outsider taking a pop at her parental objects. I am all of those things, but goodness only knows what would happen if we had a discussion about the future of therapy based on actual facts.

The privatisation of madness

I've been wanting to talk about money for a long time, mainly because I don't have enough of it. When that opportunity came up, to present along with David Graeber about money at the BPC we seized it and asked the question how we might organise ourselves into a better position to think about, talk about and negotiate money within our profession.

Like many people working in mental health, this is not my first career. Coming from a union background I am dogged by an anger about how hard it is to raise the subject of wages. My political position is influenced by working as an adult educator and organiser for 15 years and is sufficiently digested to be mercifully short. I believe that adult education and psychoanalysis are both emancipatory projects and whichever way you cut it growth means facing up to both internal and external oppression.

Moving between these two worlds of activism and psychoanalysis is increasingly straight forward, held together in our minds by some bearded blokes including the educator Paulo Freire who understood the deep developmental stream from which these two crafts come. Activists and psychotherapists clearly share some important tools - dialogic methods, seeing the world as it is, building our sense of ourselves as agents in the world, a reliance on collectivism and the bitter pill of dependency.

Working within a context of economic crisis helps to re-establish these connections, with professional audiences ready and willing to think about the basics. Increasingly people working in mental health are on the political frontline of welfare cuts and social justice - and many define themselves as activists. All that's happening now is that crisis is drawing out the essentials of what we do, with the exception of an honest debate about money.

So why is it so hard to talk about money? One of the reasons is that we have superegos like tanks: huge, defensive and aggressive. Despite everything we know from Freud, we can retreat into a world of magic solutions and magic ideological wands and nurture a deep need to take the moral high ground. There's nothing wrong with being right, but we are dogged by punitive and often sadistic states of mind which blunt our humanity to ourselves and each other and with it our need for such things as wages and decent jobs. The love between us is powerful - but we make massive demands and judgements on each other and find it very hard to respond to each others material needs. We work in situations where all of us at points work for free, made to feel the guilt and shame of not being able to articulate a need for cash.

As work gets more traumatic in health and social care we defend ourselves by splitting the working world into the them's and us's. This next bit might smart because its an internal conversation that many of us dedicated open minded and thoughtful folk fall into.

Splitting divides our profession between women who married rich men and can afford psychoanalytic training, experienced NHS clinicians who have retreated into private practice taking with them the last generation of pensions and all the world's resources with them. Versus the chippy lefties, community mental health workers, NHS whistleblowers etc etc who couldn't get over their own needs and trauma enough to become real psychoanalysts and are left stewing in their own righteousness.

This is very a very depressing thought for the anarchosyndicalist-feminists amongst us to live with.

One of the ways in which we might find a more humane perspective which respects our political, professional and personal needs might be to understand the context within which we do it using an employment relations perspective.

[Last week the CQC produced a sobering report about the crisis in mental health services.](#)⁴ Chaotic commissioning and sustained cuts in mental health services leading to the profound conclusion that if you reach a crisis on your life and you need some compassion or care you should head to the nearest police station rather than A&E.

[In the same week the Guardian's ClockOff survey came out measuring the stress levels of public sector workers](#)⁵. People working in health are the most stressed out public servants, with 61% reporting that they are stressed all or most of the time.

These reports are not about failures of individual compassion or positive thinking, rather it highlights the impact of precarious work on our states of mind. Mental health has always been the poor cousin of public services, affecting not just those of us using those services but also those of us providing them. Working in mental health has become a text book definition of precarity.

The debate about precarious work is a defining one in the field of employment relations, making the research link between between nationally set cuts and targets, privatization of services and growth of externalised labour, the use of command and control management, work intensification and bullying cultures.

The confusion and ignorance about the employment relations system of psychotherapists is very much about the continuous privatization and restructuring of the NHS and the 2013 shift of commissioning powers to local level. However it also exposes a range of employment relations problems faced by psychotherapists, including the growth of contract and agency labour, the use of unwaged labour, the insecurity of 'permanent' psychotherapists in the NHS and the retreat into private practice. We will look at each problem in turn.

⁴http://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcrisiscare_full.pdf

⁵<http://www.theguardian.com/society/2015/jun/10/stress-working-public-services-survey>

The advent of agencies is nothing new in healthcare but with the massive rise in demand for mental health services, NHS cuts and waiting lists of between 6-18 months we are now seeing the creation and expansion of private contractors and employment agencies for therapists. Because of the intense insecurity of agency work and the fear of blacklisting of individual therapists, nobody wants to talk about this growth of third parties in mental health and, as a result, not much is known about them.

The growth of contract and agency labour is part of a national campaign to downgrade mental health services. Under the NHS's Increased Access to Psychological Therapies (IAPT) the main bulk of services are low intensity 'wellbeing' programmes, based on a diluted model of Cognitive Behavioural Therapy (CBT). This service is delivered by Psychological Wellbeing Practitioners, a formalized and standardized role with intense targets of 8-10 satisfied clients a day. Under this system if a patient does not pick up the phone for an initial assessment within the allotted 15-minute time period they are referred back to their GP, presumably to wait for a further 6 months.

This model of 'wellbeing', to be clear, can under no description be considered as therapy. Although most of the people working as PWP's are highly qualified their job is not to provide a space where patients can actually say what is on their mind. The work is scripted, manualized and always leads to one compulsory outcome which is that everyone feels well. Computer says no. PWP's who offer more support, mainly through giving more time and going off script, are forced to keep this secret from employers because it breaks their contract of employment, leaving them to carry the full ethical and clinical consequences of their interventions.

To add insult to injury, tucked away in the ⁶[2015 Budget](#) is the proposal that IAPT services should be introduced to 350 job centres in the UK. The 'psychologization' of poverty where unemployed people are forced by precarious PWP's to internalise a global economic and social crisis. In this scenario its hard to imagine who needs the most help, the client or the clinician.

A growing percentage of IAPT services are provided by contractors and labour agencies who are literally buying up the growing NHS waiting lists. As with all externalised employment relations, it is not just the contract of employment that gets passed over to third parties, it is also the responsibilities of employers. Many people working in the NHS via agencies receive no training or supervision raising questions about the duty of care to

⁶<https://www.gov.uk/government/publications/budget-2015-documents>

clients and employees.

The second employment relations problem in psychotherapy relates to internships, or the widespread use of honorary psychotherapists. The most important part of your training as a psychotherapist, along with your own personal therapy, is to carry out clinical work. In order to train as an adult psychotherapist and become an accredited member of a professional body you have to work part-time - usually 1-3 days a week for between 4-8 years. The problem is that the trainee is not paid. There is currently no comprehensive data on how many psychotherapists work unwaged as honoraries, but with 6,000 psychotherapists being trained every year a conservative estimate is that 2,000 full time jobs in mental health are covered by unwaged workers. This includes a substantial percentage of the psychotherapists working for the NHS, the big 3rd sector providers such as Mind and many local mental health charities providing clinical and wellbeing services in the UK.

The professional bodies are complicit in this system of unwaged work leading to the curious situation that the bodies charged with building a sustainable profession are currently not able to do that. If there is a political cause worth fighting for it is to make the demand for our professional bodies to organise a platform to negotiate wages.

As a result this is a profession open primarily to people from families rich enough to support them. There are some who work full time and do the training on top, but there is a real risk that (as in other fields such as the media and the arts) the great majority of practising therapists will be people from affluent backgrounds. That is not to say that rich people make worse therapists than poor people, but it does raise important questions about class and power both clinically and within the profession.

The third employment relations problem relates to therapists employed directly by the NHS. In most cases the days of 'permanent' contracts are over, with cuts in funding and increasingly short funding cycles meaning many of the jobs are fixed and short term. Most NHS services are understaffed, particularly in Child and Adolescent Mental Health Services (CAMHS) leading to an emerging gold rush for private contractors and agencies. The insecurity of NHS workers has profound implications for 'workplace fear' and creating cultures where clinicians are reluctant to raise concerns about patient care. ⁷[Despite the important debate going on now about raising concerns in the NHS](https://theconversation.com/nhs-guardians-wont-help-whistleblowers-unless-theyre-protected-from-bullying-too-37543) the reality is that precarious workers are unlikely to speak up for fear of victimization and job loss.

⁷<https://theconversation.com/nhs-guardians-wont-help-whistleblowers-unless-theyre-protected-from-bullying-too-37543>

As a result, many experienced psychotherapists have retreated to private practice, unable and unwilling to navigate a broken system. Many make enough money to survive, but only having spent most of their working lives in the NHS leaving their pensions intact. This generation of psychotherapists will retire within the next 5-10 years leaving behind a whole generation of self-employed psychotherapists, many of them working within social enterprises and charities, who will never earn enough to cover the basics of pensions or sick pay. It is not to say that private practice does not offer massively needed services, it does, and a careful assessment and referral can make the difference between life and death. But it increasingly means that services are accessed only by those that can afford it.

The current economic argument for mental health services is based on the unacceptable working conditions of thousands of mental health workers. From Psychological Wellbeing Practitioners, [to IAPT workers in job centres](#)⁸ to the clinicians employed by Maximus and Atos to carry out welfare assessments, working in mental health poses significant health risks to both clients and clinicians. As long as psychotherapists are working quietly and diligently under precarious conditions the NHS as an employer will never respect the people who work for it. In a context of deteriorating mental health services, the fact that psychotherapists are an unorganised and silenced group of public servants is a matter for both professional and personal ethical concern.

⁸<https://www.indymedia.org.uk/en/2015/06/520756.html>,

Public Service

I'm going to tell you a story about the most radical shift in the NHS you've never heard of. After the weekend we've just had, this runs the risk of looking out of touch but the systemic dismantling of funding and governance of public services is very much part of the violence we're now living through. Let me explain.

Last week I went to a conference about Sustainability and Transformation Plans (STPs), held by a well known health policy and research foundation populated by the new generation of blue-suited corporate account managers and a few good people of a clinical persuasion. The beards have gone, but a glance around the room is sober confirmation about the consequences of 'strong and stable' leadership on diversity and class participation in public service debates.

At the end of a long air conditioned day of power points about innovation, the head of the NHS Confederation, who as it turns out by pure coincidence is head of an STP in the South West, explains how he manages the massive funding gap. He says, as if amongst friends, 'well, we're moving acute care into the prevention and wellbeing sector delivered in the community using student nurses who are really cheap!!!?!'. Then he actually laughs out loud.

Yes, the way that the NHS is planning on stopping people overwhelming their GPs or A&E is by not paying decent wages. Actual healthcare jobs replaced by social prescribing and community empowerment. If you work in mental health this comes as no surprise, where the third sector is filling the health funding and governance gap through the unwaged work of trainees.

As the proofs came in for my book *Surviving Work in Healthcare* last year there was a moment when I thought about putting a match to the whole manuscript because of the emergence of the Sustainability and Transformation Plans (STPs). Nobody had ever mentioned STPs throughout the whole process of writing this book and yet only a few months later their introduction by stealth threatens to obliterate what remains of patient led care.

In response to the NHS deficit, in 2014 the Chief Executive of the NHS in England, Simon Stevens proposed A Five Year Forward View which aims to maintain quality services through innovation and cost savings in return for additional governmental funding by 2020-21. A key part of this plan is the creation of Sustainability and Transformation Plans (STPs), which despite their progressive name stand to be probably the least sustainable

plan for [NHS restructuring](#)⁹ to date.

STPs, clustered in acute and specialist care which represents the main bulk of the NHS deficit, are tasked with eliminating the gap between costs and funding by creating 44 'local health systems' that create 'footprints' for planning and delivering care. If they manage to do this in 2016/17 they can access £2.1bn of 'transformation' funding, not actually new money but part of the £10bn NHS funding agreed in the 2015 spending review. The main bulk of this £2.1bn will go to emergency care, and smaller pots for efficiencies and transformations in service delivery.

The first thing to say is that these are not 'local' in any meaningful way. The STPs are massive structures covering on average 1.2 million people, merging local authorities and CCGs. Its hard to see how bringing together an average of five CCGs into one group could possibly lead to more local control over planning and securing good deals with local providers. If the last three decades of neoliberal economics and the consolidation of finances into a smaller number of corporate hands is anything to go by, its hardly going to put commissioning power in the hands of civil society.

Secondly, the timescale for the creation of STPs made it impossible for these local actors to even call a meeting let alone carry out a serious strategic and inclusive exercise. The final STP Delivery Plans were supposed to be submitted on the 21st October 2016. These full plans were not published, rather they were sent to NHS England for revisions, with publication in mid-December. On the 23rd December 2016 CCGs had to sign two year operational contracts with providers, starting on 1 April 2017. Even for the most committed local health campaigner, if you knew about these deadlines the chances of organising a genuine consultation around them were extremely unlikely.

These leaves STPs with the Kafkaesque job of ticking the sixty diversity and inclusivity boxes that they are required to do knowing full well that the real stakeholders have been left without any meaningful role to play. At its very best, this offers local health groups the option of a headless chicken approach to health management. At its worst it will lead to a radical decline in patient care and safety.

Now for the really funny bit. The principle requirement for STPs is that the Local Authorities, CCGs and providers that form the main bulk of these STPs have to square the circle of health and social care funding by cutting expenditure enough to stay within their budgets for 2016-2017. If they over spend, and do not improve patient care at the same time they will not be able to get any further 'transformation' funding. Funding is dependent on [cuts](#)¹⁰.

9 <https://chpi.org.uk/wp-content/uploads/2017/01/The-Sustainability-and-Transformation-Plans-a-critical-assessment-FINAL-WEB.pdf>

10 <http://www.health.org.uk/news/new-research-shows-%25252525C2%25252525A32bn-social-care-funding-gap-putting-local-health-reform-plans-risk>

Campaigning groups that very quickly mobilised around blocking STPs, such as in Liverpool, estimated that the plans include an implicit target to cut NHS spending by a further £25.5bn. They call them Secret Theft Plans or Slash Trash and Plunder.

If the books already don't balance, STPs are just being tasked to cull staff and services by the end of 2017 in order to secure future funding. The easiest way to do this is to pay those shiny tech companies money to digitise as much care as possible and then employ underpaid or unwaged non-clinical roles when only humans will do. Most of this activity does not count as actual care, its tinkering round the edges. I'm reminded of a Fordian industrial relations joke "You can have whatever mental health service you want as long as its online cognitive behavioural guided self-help".

This cuts-dressed-as-innovation is familiar to those health warriors who were involved in the creation of CCGs where cuts in budgets combined with devolution of healthcare provision to local services and penalties for not implementing impossible targets worked very well in shifting the burden of responsibility from the government to local stakeholders. The task of balancing the NHS's books in one year while at the same time improving patient care is literally impossible leaving STPs with the option of failing or gaming.

Don't get me wrong, nothing gets my heart beating faster than a working class GP controlling resources across millions of people. I think that's a good thing. But to pretend that this radical re-shift in managing services is a step towards genuine partnership across services and the co-creation of patient led care is a profound sleight of hand.

Although some good people are tucked away in STP leadership, many are politically naive working with the blue-suited engineers of a profound attack on public service. It's an actual fact that I'm prone to the paranoias but what is happening here is a concentration of power, not delegation of it.

This strategy of cutting public services by bureaucratic stealth has already taken place in the police, the army, prisons, and schools engineered by the same political leadership now dismantling public health and social care. When a political party talks the talk of governance it's good politics to judge them on the basis of whether they're walking the walk of government.

What is happening right now is a full on passing of the public service buck. When you vote this week, vote for a party that is prepared to govern and fund healthcare, rather than do a state led dump and run on our public services.

Hard working people

For anyone working in health and social care the link between work and welfare is obvious. [From therapists advising patients on how to survive a ‘fitness to work’ assessment to the clinicians working for the private contractors making those assessments the mythology of scroungers versus hard working people](#) doesn't cut any ice.¹¹

Even if you missed the End Austerity Now march the other week you may have noticed that welfare in the UK is on its knees. The government's flagship welfare reform combining six welfare programmes into one under the [Universal Credit has totally failed](#)¹². [Unrealistic and random cuts conflated by the failure of Atos, the large private contractor, to deliver the DWP's review of incapacity benefit leaving millions of people without money to live.](#)¹³

[Disability benefits have been transformed into Personal Independence Payments where ‘clients’ can ‘choose’ their care from a range of ‘service’ providers](#)¹⁴. Incapacity benefit reform is driven by budget cuts, with decentralization of budgets masking the reality of 20% cuts under the banner of customer choice. With this year's launch of the DWP's new [National Health and Work Service](#)¹⁵ covering sickness absence, delivered by the US contractor Maximus, you don't have to be disabled to have an interest in who delivers public services. The service will assess anyone likely to be off work longer than 4 weeks playing a perverse game of assessing the presence of ‘fitness’ while avoiding eye contact with actual ‘sickness’.

In the UK the number one cause of long term absence is mental illness, predominantly depression and anxiety. You can therefore safely assume that the people sent for assessments will be treading the thin line between distress and despair.

If you manage to convince a Maximus temp that you are not fit (presumably the easiest way to communicate that is to be unable to go through with the assessment) the question remains how do you then get back to work? With 75% of people getting no treatment for Mental Health Problems after visiting their GP how are people going to get better?

11 <http://www.smf.co.uk/the-myth-of-the-welfare-scrounger/>

12 <http://www.theguardian.com/commentisfree/2014/oct/27/universal-credit-failure-timetable-costs-iain-duncan-smith>

13 <http://www.theguardian.com/society/2014/nov/08/fitness-to-work-assessment-backlog-maximus-health-services-atos>

14 <http://www.theguardian.com/politics/2014/sep/17/delays-personal-independence-payments-disabled-people-unacceptable-welfare>

15 <https://www.gov.uk/government/publications/2010-to-2015-government-policy-employment/2010-to-2015-government-policy-employment>

[The reality is that since 2008, sickness absence has gone down](#)¹⁶. This is not just because everyone has officially become fit, its also something to do with the fact that we're working in a climate of fear. More people will keep working until something goes very wrong, a total reversal of good health policy which emphasises early intervention. If you get really sick it means expensive intensive care which at £600 a night wipes out any possible gains to the UK economy of struggling on at work for a few months.

The language of welfare is very important. In order to cut welfare and the costs to the UK economy of people getting sick, dis-ability got banned and replaced by a ruthless regime of positivity. We no longer ask what's wrong, just what's right. Fitness became compulsory. With this linguistic slight of hand the social contract between the state and the people that live in it is transformed into a commercial contract signed with heroically named private companies.

This is a narcissistic regime where needing help is a sign of failure and and the world becomes divided between scroungers and hard working people. The state projects its duty of care into the private sector and then projects this societal failure into the individual. [This is reflected in the growth of suicides](#)¹⁷, [now the number one cause of death of men under the age of 50](#)¹⁸.

Another reason why health and social care workers understand the connection between welfare and work is because of low pay.

[Since 2009 the number of people earning less than a living wage has increased from 3.4 million to 5 million in 2014](#)¹⁹.

[The government's proposal to cut £5bn tax credits](#)²⁰ has exposed the reality that 7 million working people don't earn enough to live. Despite the government not providing data on this, an estimated 1.5 million working people need housing benefit to pay their rent, [a number that is going up by an estimated 10,000 people every month](#)²¹. This year the United Nations reprimanded the UK government for its 'bedroom' tax on the basis that it abused

¹⁶<http://www.cipd.co.uk/pm/peoplemanagement/b/weblog/archive/2013/01/29/absence-unwanted-presence-2011-01.aspx>

¹⁷<http://www.mirror.co.uk/news/uk-news/more-80-suicide-cases-directly-5634404>

¹⁸<http://www.ons.gov.uk/ons/rel/vsob1/mortality-statistics--deaths-registered-in-england-and-wales--series-dr-/2012/sty-causes-of-death.html>

¹⁹<http://livingwagecommission.org.uk/about/>

²⁰<http://www.theguardian.com/politics/2015/jun/24/harriet-harman-labour-attacks-david-cameron-over-tax-cuts-and-pay-levels>

²¹https://fullfact.org/factchecks/housing_benefit_affordable_national_housing_federation_employment-28543

our [human right to shelter](#).²² the fallout of this linked to the rise in homelessness in the UK <http://www.homeless.org.uk/facts/homelessness-in-numbers/statutory-homelessness>.

The people receiving in-work benefits are mainly women and single parents, many of them working in health and social care. [One third of people working in the NHS earn less than a living wage](#)²³. With pay freezes and reduction in collective bargaining the real value of NHS wages have gone down over the last 5 years <http://paycalculator.unison.org.uk>. Of the 1.4 million people working in social care, [160,000 are earning less than the minimum wage](#)²⁴ particularly domiciliary carers who are paid only for the 15 minutes of contact time and not their travel between clients.

Not earning enough to live puts us in a precarious position and when we are precarious at work we are vulnerable to burnout, bullying and failures in our duty of care. Compassion is hard to squeeze out when you have not been able to afford lunch on a 12 hour shift.

One of the reasons for low wages in health and social care is the decline of professional bodies and trade unions that have historically fought for wages and conditions. [The Social Care Association closed in 2012](#)²⁵ and last week saw the closure of the College of Social Work set up after the case of [Baby P](#).²⁶ Both of these bodies provided the professional framework for their sectors, and both were closed due to pitifully small deficits in funding. If we had wanted to maintain these bodies we could have, easily.

In Julian Lousada and Andrew Cooper's important book [Borderline Welfare](#)²⁷ they thoughtfully argue that when we lose the institutions of welfare we lose the general conditions that are necessary for care to take place. What we are left with is lots of activity that is done by increasingly vulnerable individuals trying to bridge a massive governance deficit. By not maintaining the institutions of welfare the state fails in its duty of care to create the conditions under which health and social care work can responsibly be done.

A second problem is the lack of union power in these low wage sectors. Having worked

²²<http://blogs.spectator.co.uk/coffeehouse/2013/09/leaked-emails-reveal-united-nations-fury-at-bedroom-tax-report/>

²³<http://www.unison.org.uk/at-work/health-care/key-issues/nhs-pay/home/>

²⁴<http://www.resolutionfoundation.org/publications/the-scale-of-minimum-wage-underpayment-in-social-care/>

²⁵<http://www.communitycare.co.uk/2012/11/01/social-care-professional-body-forced-to-close/>

²⁶<http://www.theguardian.com/society/2015/jun/19/college-of-social-work-closes-financial-difficulties-baby-p>

²⁷<http://www.karnacbooks.com/product/borderline-welfare-feeling-and-fear-of-feeling-in-modern-welfare/17086/>

for 15 years in trade unions I am not neutral about the value of solidarity, but I am realistic about the deficit of leadership that the crisis in health and social care is linked to. Notwithstanding, the reality is that the key reason why wages are going down is that precarious workers generally don't join unions, and are hard to mobilise around collective bargaining. There are over 200,000 active workplace representatives in the UK doing what they can to organise people into unions. Most of them do this without pay and for the right reasons. Whatever your politics, unions up until this point have been the only show in town in negotiating wages and their inability to defend the wages of health and social care workers is not a political problem but a genuinely social one.

Crisis brings us face to face with one of the unavoidable facts of life that we are all dependent on each other. As the containment of public services breaks down social anxiety goes up and the temptation is to manage this by projecting our vulnerability into others from Greek pensioners to public sector workers. The demand for cuts is a defence against this anxiety precisely because it denies our inherent need for care. Despite the rhetoric, austerity is not principally an economic issue because by cutting welfare and wages we do not save money, merely we pass the buck to the people needing and providing care. Even by drawing borders between people - between the sick and the fit, scroungers and hard working people - we can never successfully cut ourselves off from the reality that as human beings we are inherently vulnerable. Cuts are a defence but a useless one because by cutting off from each other we lose our best chance of survival. It means that in health and social care knowing the real value of welfare is a matter of personal and professional survival.

Just Surviving

Despite being a reluctant participant in the UK's wellbeing industry, when I hear the words 'survive and thrive' I feel the bile rising up. As someone who works under the title of Surviving Work it's been a long running and daily process to explain why I'm so bleak about the prospect of thriving.

In my defence I'd like to say that in my experience the people who have a problem with the word 'surviving' without 'thriving' are generally doing well. Many of them in my experience are paid well and in senior positions. "But Elizabeth, some of us actually ENJOY our work!!!!!!".

These are often the same people who spent the mental health awareness week giving possibly the worst advice imaginable in a recession, that the mental health crisis in the UK can be solved by people disclosing their mental health problems.

Deep breath.

I'm reminded of 2014 when I spent a whole year trying to raise money developing a wellbeing at work App called No Punching or Spitting.

I'm trying to say this really calmly now, but I strongly suggest you do not disclose your mental health problems to employers unless a) they are an ethical and progressive employer with a clear anti-discrimination and anti-victimisation mental health policy b) there is a functioning trade union in place c) you absolutely have to. If you can't tick all three boxes don't, just don't.

Another deep breath.

All the statement that someone is 'surviving and thriving' says is that some people are happy in work. For now. What it does not say is that any of us can skip past the realities of working life like young gazelles. Seriously, ignorance about mental health at work is not a good strategy.

Added to which it's pretty rude to downplay the problems that many of us experience with work in the current climate. On a bad day in higher education, just as a completely random example, the insistence that it's possible to feel great at work brings a rage channeling Genghis Khan.

As anyone speaking from a position of actual experience of mental health problems can testify, you're OK until you're not.

The other day I was speaking at a mental health event for doctors, presenting my profoundly bleak view of what it takes to survive working in healthcare. Rather than appearing to be a total hypocrite and racing out of the door after my performance I sat through the following session on mindfulness. Tearful testimonies of a breakdown, 'fun' pictures on the ol' power point and a psychological activity attempting to prove with absolute certainty that in order to function at work we just need to do more meditation. Then the ideological punchline. A slide that proves categorically that mindfulness = happiness = going to work = alls well with the world. A massive drain on our collective good will takes place in our attempt to humour a twenty something person who has no concept of how brutal the world of work can actually get.

Tempting as it is to dance on the grave of workplace wellbeing it's worth knowing how we got ourselves into this mess. I'm now going to lay-in to Layard. See what I did there?

In addition to being the daddy of IAPT, the UK's largest public mental health service, Richard Layard of London School of Economics fame has laid the foundations for a national drive in wellbeing and 'happiness' initiatives in the UK. The specific model of wellbeing that is being used is based on positive psychology, developed by the American psychologist Martin Seligman, which is based on the principles of CBT promoting 'positive' cognitions and behaviours. Within this model, wellbeing is encouraged through positive thinking and behavioural exercises using educational and mindfulness techniques that aim to reduce the symptoms of depression and anxiety and increase levels of optimism.

Note to self. Symptoms not causes.

This wellbeing model has been aggressively promoted in the UK, most recently at an LSE and OECD co-sponsored conference on subjective wellbeing, where Layard provocatively argued in the media that wellbeing, measured on the basis of people's reported subjective satisfaction levels, is not based on income rather on our relationships and health levels, specifically the absence of mental illness.

Despite the meteoric rise of health inequalities research, including a sickening report from the [Equality Trust](https://www.equalitytrust.org.uk)²⁸ that the richest 1000 people in the UK have wealth equivalent to 40%

²⁸<https://www.equalitytrust.org.uk>

of the population, apparently money doesn't matter.

From an employment relations perspective, workplace wellbeing programmes are often viewed with some scepticism partly because they depoliticise the issues facing workers. Trade unions have been highly critical of 'resilience' agendas precisely because of the emphasis on individual cognitions and behaviours which under-emphasises external factors such as working conditions or, in lay terms, crap jobs.

It's also pretty slippery to pretend that the growth in the wellbeing sector hasn't happened during a period of profound welfare reform and austerity. Despite the powerfully obvious and painful failures of Universal Credit, Employment and Support Allowance reform and the use of sanctions, this combination of wellbeing and work remains central to government policy.

If you're voting in the next election, you might want to re-read that paragraph.

This compulsion to wellbeing is a particularly painful issue for health workers. Research into the health of health workers is a source of great contention and more than a degree of irony. A 2015 survey of senior hospital doctors showed that 80% are considering early retirement and a Mind research report in 2016 said that 88% of primary care workers find work stressful with 21% developing mental health problems. Even more chilling is the reality that along with the UK population, most health workers are taking medication to deal with this.

As a result, state funded positive thinking provokes a deeply cynical response from clinicians when there are attempts to build their collective 'resilience' through training designed to bolster their toughness, including the ability to 'bounce back' from adversity. As 74% of GPs say their workload is unmanageable the current suggestion that they might want to lay off the vino and go to Zumba may be met with some hostility.

Rather than just giving up on health for health workers lets try to pull ourselves together.

The main objective of my book is to present my best shot at giving you some useful ideas about how to survive work in healthcare. If you do not have time to read this book I can summarise for you everything I know so far:

- Don't blame yourself: understand the social, political and economic factors that make your work what it is

- Don't keep calm and carry on: find a way to actually feel what you feel about that - from anger to the need to punch and spit, feel it and find ways to express it that will not end up with you losing your job
- Don't be brilliant: resist the temptation to be a superhero and single handedly overcome the systemic failure of welfare capitalism. Try to be an ordinary person.
- Don't go it alone: just stop fighting the obvious that you have to get on with the people you work with enough to talk to each other and where possible collectivise around what is important at work

Yup, wellbeing at work rests on taking a political position. Time to dig deep and become healthcare citizens, not just clinicians.

If I wanted to be patronised....

Before I start I'd like to say that I don't hate Cognitive Behavioural Therapy. I think any high quality therapy delivered by a huge hearted and experienced clinician can be useful to anyone. I don't believe that any one model has mental health cracked and I am a depressed realist when it comes to where you can get help in a recession.

I do however have an issue with the hubris around [positive psychology](#)²⁹ which is based on cognitive and behavioural interventions, and how it gets used by ideologically driven governments and patronising employers to punish people with problems. In the case of workplace wellbeing or mental health services I think that short term interventions are often more harmful than not, both to the patient and the clinician. I also believe that just because someone says there's an evidence base for a practice now being exported across the globe doesn't mean its actually true. The spread of positive psychology is also a story of power and money. It's cheap and if it doesn't work leaves the individual carrying the systemic failure that promotes positive thinking as a long term response to social crisis.

On the 9th May I joined 1000 people at Friends House in London to listen to the daddy of positive psychology, [Martin Seligman](#)³⁰. Agreeably not my usual tribe but I went to get my critical brain working again to help write an academic paper on how we might construct a progressive model of mental health.

We kicked off with a fake listening exercise: think back to the last week about something positive that happened and tell the person next to you.

I am stuck with a 26 years old positive psychologist who talked about her boyfriend's bbq that weekend. I can hardly open my mouth thinking of the young black man I'd talked down from jumping in front of a tube train last week while about 30 people on the platform literally looked the other way. I squeezed something out about being grateful for being able to be more open with my friends about how I'm struggling. She thought I hadn't understood the question.

Having worked in adult education for several decades I'd like to suggest that if you want people to say what their reality is you have to ask them a genuine question rather than signpost them into a neurolinguistically programmed cul-de-sac.

²⁹<https://www.authentic happiness.sas.upenn.edu>

³⁰<https://www.authentic happiness.sas.upenn.edu/faculty-profile/profile-dr-martin-seligman>

What follows is my stream of consciousness during the event enacted on twitter with real time reactions.

@SurvivingWk Uh oh flashback to 1983 #RoyalWeek at #MartinSeligman event tonight. Very positive people, plus me (picture of a full hall young shiny mostly women)

@SurvivingWk Always look for the nearest exit in case of #positivitycompulsion at #Martinselgiman talk tonight (picture of the exit I'm sitting next to. I literally could not find a seat any closer to the door)

@SurvivingWk Just realised I saw #Martinselgiman outside Friends House looking miserable. I like him more. Damn.

@SurvivingWk 5 minutes in & despair sets in. #richardlayard offering a benign overview of wellbeing industry #happynow?

@SurvivingWk Damn that #Martinselgiman. Tres charming - I feel a #positivepsychology seduction coming on.

@SurvivingWk "the past does not determine the future" #Martinselgiman #theendofhistory

@SurvivingWk "we have to put critical psychology on its head" aw bless #Martinselgiman clearly hasn't heard about welfare reform #mentalhealthcrisis

@SurvivingWk "Freud told us the best we could do is not be miserable...empirically false, morally irresponsible & a political dead-end" #Martinselgiman

@SurvivingWk Its all going a bit Pete Tong in my head and we're only 25 mins into #Martinselgiman talk. A real slight of hand about human experience

@SurvivingWk I wonder if #Martinselgiman has ever experienced utter despair and real powerlessness? #viciouspositivity

@SurvivingWk It's funny how understanding anything has been written out of human psychology in #positivepsychology #keep'emignorant&busy

@Survivingwk "4 million people lie about their happiness" #martinselgiman's

authentichappiness.org. You think that's because it's an online checklist?

@SurvivingWk "40,000 women on social media talk about shopping & yay!!!" if I wanted to be patronised #martinselgiman I'd just go to work.

@SurvivingWk I think #martinselgiman is predicting the end of psychology research through his analysis of Twitter activity.

@SurvivingWk Shoot me now. Wellbeing education through happiness exercises. Clearly #martinselgiman hasn't done a workshop on bullying in NHS recently

@SurvivingWk Haha actually surreal. #martinselgiman advises student who works in library until midnight to use their "humour strength"...

@SurvivingWk Urm shouldn't you be telling your students that working until midnight is utterly disastrous for their #mentalhealth? #chearuplove

@SurvivingWk I've actually stopped breathing. #martinselgiman now talking about happiness education of 8000 kids in Bhutan #humanrightsanyone?

@SurvivingWk 700,000 kids in Peru apparently VERY HAPPY using #positivepsychology...deeply challenging un-thought has set in

LinkedInFriend: "Hi...I am using positive psychology as one method in improving employee relations performance. One of the outcomes was a 50% reduction in BME disciplinaries.

LinkedInSurvivingWork: " Sure as a technique its useful but not as a response to poverty in Peru (a country I worked in for 10 years), a failing mental health system or as a substitute for a decent employment relations system. I have heard about your great work through a colleague Mr X. I work a lot with health workers and there is a very important push back against using techniques to control rather than empower people. Very best."

LinkedInFriend "Completely agree with you."

@SurvivingWk "happiness is political about the goals of good government" #martinselgiman I'd settle for a welfare system & action on climate change

@Friend1 I would settle for holiday money, sick money & a pension #England

@SurvivingWk Yeah but that's just learned helplessness. If you're near Euston help me.

@Friend1 no actually its our government who sign agreements on our behalf, which they would never accept #doublestandards

@Friend2 I much preferred him in the 1970's when he was into learned helplessness, so much easier to relate to than positive psychology

@SurvivingWk I'm drowning in vicious positivity. Come save me!

@Friend2 Sure you will be a better person for the experience. Just allow all the positivity into your inner self- oh and ignore reality

@SurvivingWk You're not helping. I'm drowning comrade

@Friend2 In which case its between asking a devastating question, a quick burst of The Internationale or escaping to the nearest pub

@SurvivingWk If I could remember the words random singing would be preferred option.

@SurvivingWk I will be lynched if I show evidence of independent thoughts. Pub by default. Plus side I'm genuinely pleased to be me now.

@Friend2 Surely that just shows the paradoxical power of positive psychology?

On the bus home I have a sinking feeling that I've gone too far and expect to wake up to a tirade of violent positivity. The next day there is no response, literally none. Now, it could be that I just didn't make my point clearly enough and I'm absolutely right and amongst friends on social media. But several years of low level trolling for being a woman with actual thoughts this just feels a bit spooky.

Although I'm open to nobody giving a bummer about what I have to say, given the religiosity around positive thinking I think its likely that we just can't think about this. A reluctance to chip away at our only remaining 'magic solution' to be happy in a complex world.

For me this reductive version of reality has never been an option. Sure it makes me feel

like I just failed my positivity exams but then if I wanted to be patronised I'd just go to work.

Imperfect institutions

During the run up to the election, I've been focussing on fighting the urge to go off on an existential huff. The announcement that a Conservative government would employ 10,000 new mental health workers to deal with the profound lack of care in our society, and my honest reaction was how are you going to find enough 22 year old psychology graduates to be the interns to deliver those free mindfulness courses?

That something is really failing in public services is a given for those of us who rely on them. What is more painful during a political campaign is the dawning realisation that so is our belief in them. Despite the campaigns to put the institutions of care in centre place in our voting decisions such as #voteNHS developed through the wonderful [Health Campaigns Together](#)³¹, its a tough gig to stand up for these profoundly imperfect institutions. Despite the pressure to show support for public services when they fail us its hard to maintain our belief in them.

Working in healthcare can be really depressing. I mean that in its existential rather than clinical sense. Many of us working in healthcare spend periods feeling hopeless - the belief that what we do matters eroded on a daily basis. This is particularly true for those of us who work in health services who need those services ourselves. The therapist who needs therapy, the nurse forced to go to A&E, we're all staring into the abyss. Every time I try to get compassionate care from my GP I have to write on my hand "[For God's sake don't tell them you've written a book about this](#)"³² because I can't afford to annoy my doctor.

Many of us working in the public sector walk the thin line of surviving work. At times our relationship with work is abusive, working without reward or a sense of belonging and taking the blame for ministerial mistakes. Materially and emotionally, the more vulnerable our own situation becomes the harder it gets to care compassionately about others.

³¹<http://www.healthcampaignstogether.com>

³²<https://www.routledge.com/Surviving-Work-in-Healthcare-Helpful-stuff-for-people-on-the-frontline/Cotton/p/book/9780415788045>

For many people working in healthcare the bigger picture is a depressingly obscure patchwork of shiny 'new' management techniques, bad news, smoke, mirrors and a sense of déjà vu. On the last day of writing my book I clicked onto twitter to find the long awaited results of a review of bursaries for midwives and nurses - all gone, replaced by student loans and unconfirmed announcements of a 40% cut in Health Education England's budget. Goodbye to the development of the next generation of frontline health workers without even pause for a headline.

What is emerging is a downgraded model of sub-care, a regime of compulsory fitness founded on gaming data and demoralised workers. This radical shift towards un-care is welcomed with wide open strategic arms by the thousands of private contractors and employment agencies waiting to negotiate the next round of health contracts. As the great and the good retire and new generations of workers enter a confused market with no sniff of a pension or secure housing, the crisis in health is about to hit a tipping point.

The decline of the institutions of healthcare has had a major downward effect on public service. The sorry state of healthcare professional bodies - although traditionally conservative and split between their various functions as representative and also regulators of professionals - has had an important negative impact on working conditions. In social care for example, the Social Care Association closed in 2012 and 2015 saw the closure of the College of Social Work set up after the case of Baby P. Both of these bodies provided the professional framework for their sectors, and both were closed due to pitifully small deficits in funding. If we had wanted to maintain these bodies we could have, easily. Our professional bodies are in crisis - torn between defending the sector and their organisation which increasingly cannot happen at the same time.

The structural conflict within the professional bodies is really clear if we look at mental health services. In 2016 I went to a mental health conference to join a group developing a Wellbeing Charter for people working in psychological therapies. I normally last ten minutes in such environments before the existentials hit, but I took this occupational risk to show solidarity to the people I work with in mental health.

This meant running the gauntlet of shiny young folk promoting Cognitive Behavioural Therapy Apps and online courses, wellbeing at work industry reps, private contractors delivering the Work Programme and welfare assessments, private employment agencies and clinical psychologists measuring the impact of self-guided resilience manuals. An MP on a podium apparently unencumbered by actual facts about his own government's inability to sign off the Universal Credit and unaware that being on welfare does not mean you are not in work, as 30% of NHS workers can testify.

As the discussions start about how we are going to build support for a Wellbeing Charter I realise that, for some, this is primarily a question of learning how to present the 'business case' and learn the creative accounting required to match targets and outputs with actually helping people. As someone who has spent most of their working life as a trade unionist I would like to suggest that the entire experience of industrial relations is that whatever financial argument you present to protect psychological therapies actually doing it will require genuine political will on both sides. To simply adopt a business school logic creates just a fiction about 'going forward'.

To make matters worse I am sitting next to a rep from an online CBT provider talking about how the clinicians they employ value the flexibility of working on a zero hour contract. It appears she has not connected the growth of 'flexible work' with the growing number of people working in mental health services do not want to get out of bed in the morning because of the culture of fear they are forced to work in. Online therapy offering a narcissistic model where neither the patient nor the clinician ever has to be in contact with another troublesome human beings ever again.

In Julian Lousada and Andrew Cooper's important book [Borderline Welfare](#)³³ they argue that when we lose the institutions of welfare we lose the general conditions that are necessary for care to take place. What we are left with is lots of activity that is done by increasingly vulnerable individuals trying to bridge a massive governance deficit. By not maintaining the institutions of welfare, the state fails in its duty of care to create the conditions under which health and social care work can responsibly be done.

Working in healthcare has always been a dual task of both improving and surviving healthcare systems. Despite our experience of the organisations of care, the institutions of welfare matter. If the entire history of protecting public services is anything to go by this will only happen if we make the decision to defend our imperfect institutions, warts and all. Vote for any party that actually commits to defending the institutions of care. We will sorely miss them if they are gone.

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33<http://us.karnacbooks.com/product/borderline-welfare-feeling-and-fear-of-feeling-in-modern-welfare/17086/>

Everyday politics

Tempting as it is to believe in political fairy tales where heroic leaders fight on the frontline for decent jobs, the realities of work point to a different story. This is particularly evident to the people working in healthcare, where a Swiss-like neutrality about the politics of work is a comfort we can no longer afford.

It's possibly a bit concrete, but I believe everything worth saying has been said by Public Enemy. In Harder Than You Think is a phrase I use pretty much every.

If you don't stand for something you fall for anything.

Say it out loud. Better in a Long Island accent.

This sentence says to me that, with the best electorally-registered-will in the world, the problem of politics at work can't be delegated to the professional politician. The nature of politics is fundamentally personal.

Politics is not a super-science, it's the everyday, messy, frustrating and deeply humane developmental process that allows us to walk the thin line between being right and slipping into the warm bath of self-righteousness. This everyday politics is a complete contradiction to a magical version of politics that survives on the belief that being right is enough.

I've spent most of my working life as an educator and organiser, over the last five years focussing on the health sector. From Thai activists in the industrial zones of Bangkok to the glorious Nepalese women working in German pharmaceuticals factories, I had the luxury of a political education such that what I believe has become part of my daily functioning. Somewhere between my heart, mind and gut. This organising work over time re-oriented my entire relationship with the outside world and with my internal one. Moving from left-wing-religiosity where I had the answer comrade, to seeing politics as a developmental and collective process, one which I couldn't do alone.

Over the last five years it has felt that anyone working in health is slowly morphing into Che Guevara, for some of us minus the beard. This is because the situation in healthcare has become so obviously unfair to both staff and patients, we are all being forced to take a position. This is not primarily ideological, it is about social justice. Easy to pretend this is a left/right split but the reality is that from both the patient and provider perspectives, something very unfair has been introduced into the system.

Still within our culture there's nothing quite like an injustice to get people onto the streets for another national demonstration. Fairness really matters to us. As someone who regularly goes to campaign meetings and events, I am pretty divided about the experience of campaigning around the NHS. One of the reasons for this is that we lost the last battle when the Health and Social Care Bill was passed, pretty much killing off the institutions of public health. The battles over the NHS teach us that when you lose a major legal challenge to protecting public services you never ever get them back. This massive defeat, according to the people who drove the opposition through the unions and professional bodies, happened because of the self-interest of the people involved and the fragmentation of the rest of us. We did not actually stick together when it mattered.

Many organisers who have been active in the battle for the NHS are of a certain age and filled with a mixture of both love and loathing for this new 'movement' that is forming around social issues such as health and precarious work.

Part of this ambivalence is a result of the bitter experience of what it actually takes to protect jobs and public services. We know from experience how hard it is to maintain public support in the long term and to get sufficient gains to keep people in decent jobs. The more precarious the worker the more likely they can be bought or threatened off the picket line. If they lose their jobs in the process they provide a cautionary tale to anyone with a collective glint in their eye.

In the workplace, the reality is that sticking together means sticking with people who you may not see as taking the same political position as you but who you need. As a result, solidarity involves an emotional job of work of remaining open to people on the people you work with, even when they don't follow the same voting pattern.

Under pressure not to mention Marx in the promotional literature for *Surviving Work* I describe this process of everyday politics using the LAUGH framework. Bit slippery of me, but necessary in these marketized times. Our tried and tested organising methods can be re-described as:

Stage 1: Starting where you are by Listening and Assessing what is going on at work and taking a position on that

Stage 2: Understanding your environment and identifying resources that you individually and collectively have

Stage 3: Getting Help from the people around you and working out how to have better relationships at work

Despite the strangely excluding and sectarian ways of some activists, these methods are actually available to all of us to use in our workplaces. Ideological posturing, like beards, are not compulsory and if you can skip the initial ten minute monologue about neoliberalism generally you can have a genuine conversation with most people motivated to improve healthcare. Activism, at its very best, is just knowing how to form relationships with people that are strong enough to collectively respond to what is going wrong at work. I guarantee that you do not need to go on a correspondence course on Marxist dialectics or spend a decade in psychoanalysis to do this. It is as simple as talking to each other.

This drive to collectivise, although beaten up in the toilets of the NHS, is inherent in us and the vast majority of health workers are naturally really good at it. For us it involves going back to our clinical roots. To start realistically, to talk, and stand up to the internal and external voices that say we cannot bring about positive change. To contain the anxieties that are flooding our consulting rooms, and take some time to think about how we work. I am always humbled by the care and concern healthcare workers show to their patients. We now need to see how we treat each other is a matter of equal political and professional concern.

Gods, monsters and the paradox of the Third Sector

In a week of Greek tragedies a strange attack on the UK's civil society is taking place. [Despite Kidsco](#)³⁴ being the most successful organisation working with poor kids in the UK the charity's founder, the charismatic Camila Batmanghelidjh, took a sustained beating from the Cabinet Office ending up in the demand for her resignation in return for £3 million of a £5 million funding shortfall.

A former government minister was [quoted](#)³⁵ "Where there has been frustration on both sides of the conversation is we had an unsatisfactory process where Camila would effectively come in and say "I'm about to fold if you don't give me £5m'. that happened on a regular basis and more often than not the hole was pugged.. There is a recognition in governments of all colours that what Kids Company do is extremely valuable and they reach parts of the statutory [social care] system that other parts do not seem to. But the charity keeps growing and there's been no retrenchment. She [Camila] cannot say no."

Putting aside the irony that welfare cuts are in response to a sudden and massive private banking crisis, it appears that Kidsco is a victim of its own remarkable success.

[In the same week Ibukun Adebayo won her case against the mental health charity Turning Point for unfair dismissal](#)³⁶. This very different story is a sorry affair of old fashioned discrimination and lack of accountability. The judgement found Princess Diana's favourite charity guilty of race and religious discrimination and a "striking degree of double standards". David Hoare, deputy chief executive and head of equality and human rights at Turning Point was found to have described Adebayo as "Looney Tunes" in an email to Lord Victor Adebawale, the chief executive, and made fun of her Christian beliefs. In a crippling disclosure Mr Hoare's email sent to another Turning Point director was read out where he jokes that Mrs Adebajo had been "taught to kiss by a girl.....We all have to start somewhere. I got my first blow job from [name redacted in tribunal document]". Unlike Adebayo, Hoare continues to work at Turning Point. You couldn't make it up.

³⁴<http://www.kidsco.org.uk/about-us>

³⁵<http://www.theguardian.com/society/2015/jul/03/camila-batmanghelidjh-government-briefing-kids-company>

³⁶<http://www.standard.co.uk/news/london/diana-charity-chief-set-for-payout-after-boss-branded-her-looney-tunes-and-sent-obscene-email-about-her-10371214.html>

Add to this the [Daily Mail's exposure](#) of the 'boiler room'³⁷ tactics of the big charities including Oxfam, Cancer Research and Save the Children to raise funding from vulnerable people it has become hard to distinguish the charity gods from the monsters.

The Third Sector

[Around 800,000 people work in the Third or 'voluntary' sector in the UK](#)³⁸, with over 164,000 registered charities and a combined annual income estimated at [£64 billion](#)³⁹ their role in providing social goods is not marginal.

[The state funded the third sector £13.9 billion in 2010, £7 billion of which came from Local Authorities](#)⁴⁰. [An estimated 437,000 third sector workers are employed in health and social care with 115,000 in residential care](#)⁴¹.

Much of the work with the most disadvantaged is carried out by religious groups. [Churches have historically provided services for prisoners](#)⁴² [and the homeless including social care and education](#)⁴³ with [a growing role in managing food banks used by half a million people in the UK](#)⁴⁴.

We are also seeing the growth of religious organisations being sub-contracted to provide public services, [such as welfare services in Scotland](#)⁴⁵.

[The data on sub-contracting to the third sector in health and social care is sketchy](#)⁴⁶ however with a government policy to [expand public funding to the third sector](#)⁴⁷ and the [decentralisation of commissioning in health there is likely to be a growth](#)⁴⁸.

It means that we must be able to map which third sector organisations are working in

37 <http://www.dailymail.co.uk/news/article-3154251/Now-charities-forced-action-cold-calling-Bosses-agree-clean-act-boiler-room-tactics.html>

38 <http://data.ncvo.org.uk>

39 <https://www.gov.uk/government/publications/charity-register-statistics/recent-charity-register-statistics-charity-commission>

40 <http://data.ncvo.org.uk/a/almanac12/what-are-the-main-trends-in-statutory-funding/>

41 <http://data.ncvo.org.uk/a/almanac12/what-is-the-voluntary-sectors-involvement-in-public-service-delivery/>.

42 <https://www.pecan.org.uk/>

43 <https://humanism.org.uk/404notapage>

44 <https://policy-practice.oxfam.org.uk/publications/walking-the-breadline-the-scandal-of-food-poverty-in-21st-century-britain-292978>

45 <http://www.crossreach.org.uk> and Kent <http://www.caringhandsuk.org.uk/about/index.html>.

46 <http://www.nao.org.uk/wp-content/uploads/2005/06/050675es.pdf>

47 <http://dera.ioe.ac.uk/7133/>

48 <http://www.birmingham.ac.uk/generic/tsrc/documents/tsrc/working-papers/working-paper-20.pdf>.

health and social care and be able to make distinctions about organisations on the basis of their capacity to provide quality care.

Social exclusion and reaching the 'dis-established'

The most poor and vulnerable people are hard to reach. Many people living in the UK are 'dis-established' either by choice or necessity, [living outside of the social systems set up to protect them](#)⁴⁹.

Some, like people with addictions or long term mental health problems, have exhausted state support or are unable to follow the treatment available. [From illegal immigration](#)⁵⁰ to [working in the grey economy](#)⁵¹ many people are excluded from health and social care, unable to give a name and address to even register at a GP practice. We don't know how many families live by necessity outside of the social contract but as 'cashless' [welfare reforms take place](#)⁵² and poverty goes above 13 million we can anticipate [the number is growing](#)⁵³.

This is a competitive advantage of third sector organisations, that they have access to the people that need the help the most.

The Paradox of Funding

One of the inherent conflicts for third sector organisations is how public funding influences the principles on which they were established. This is acutely the case for charities, who cannot take a political position on the economic and social policies that are increasing the demand for their work. It means that an organisation like Kidsco has to walk a very thin line between continuing to access government funding and taking a position on the link between austerity and child poverty.

The lack of core funding for charities means that their accounts, although not technically corrupt, are often squeezed to fit the reporting [requirements of donors](#)⁵⁴. It means that core salaries are hidden under 'project coordination' and numerically defined outputs

49<http://www.jrf.org.uk/publications/monitoring-poverty-and-social-exclusion-2013>.

50<http://www.jrf.org.uk/sites/files/jrf/migrants-private-rental-sector-summary.pdf>

51 <http://www.iea.org.uk/sites/default/files/publications/files/IEA%20Shadow%20Economy%20web%20rev%207.6.13.pdf>

52<http://www.theguardian.com/society/patrick-butler-cuts-blog/2013/jun/03/homeless-pensioner-offered-tent-by-council>

53<http://www.jrf.org.uk/topic/child-poverty>

54https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/438017/Trust_and_Confidence_in_the_Charity_Commission_2015.pdf

exaggerated to satisfy demands for value for money. All the while the unsustainability of many services in a climate of economic crisis is denied. It means that charities are often silenced when under attack.

The corruption of civic leadership

Much of civil society is led by charismatic people who have a deep and sometimes obsessive belief in their cause.

One of the problems with this commitment is that it can generate bullying by default. Where leaders are forced to sustain themselves for decades working unchallenged their organisations can easily undermine the principles on which they are based. Many are run on guilt and the pressure for people within the system to sacrifice their health for the greater good. A demand for total devotion and self sacrifice that walks the thin line between being right and becoming righteous, believing in god and having a Jesus complex.

The growth of third sector organisations in providing health and social care raises questions about universality of access and accountability of organisations, many of which are fundamentally sectarian in nature. It also raises questions of equality and [employment practices](#)⁵⁵ for the people working within them, when issues of conscience and belief are a [requirement for the job](#).⁵⁶

Challenging leadership is always hard, particularly when they operate on the moral high ground but that's precisely what we have to do if we are to defend quality care. To do this we have to see civil society as it is rather than a world of gods and monsters. It is this realism that allows us to make the necessary distinctions between corruption and saying something that society doesn't want to hear. If civil society is to protect the most vulnerable it has to be just that, civil, with the rights and responsibilities this entails.

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55 <https://www.theguardian.com/business/2015/jul/11/the-life-of-the-charity-cold-caller>

56 <https://humanism.org.uk/wp-content/uploads/BHA-Public-Services-Report-Quality-and-Equality.pdf>

The case for relationships at work

You don't have to be an actual junior doctor to be worried about [surviving work](#)⁵⁷ in health and social care. So in this final column for [Battles on the NHS Frontline](#)⁵⁸ I'm bringing out the big ethical guns and arguing the case for our duty of care to the people we work with.

The Duties of Care

The duty of care is a complex mix of rules and professional regulations that apply to all NHS staff, articulated in the newly amended [NHS Constitution](#)⁵⁹. It means that people working in health and social care have a personal duty of care to provide good clinical care and with it a [Duty of Candour](#)⁶⁰ to raise concerns about poor practice.

The high profile NHS failures in the [duty of care](#)⁶¹ point to a real problem in getting people to speak up at work and the severe limitations of a purely regulatory system that doesn't address the real reasons why people aren't raising their concerns.

In first place, is the fear of victimisation from colleagues and employers. Yes, you heard that right.

This led to the [Freedom to Speak Up review](#)⁶² that concluded that in order to get people to speak up the blame culture in the NHS [needs to be addressed](#)⁶³.

This problem is often framed as the need to make the shift to a 'just culture' - one that makes a distinction between at-risk or reckless behaviour from just human error. A working culture that looks systemically at care, rather than taking the witch hunt school of management which individualises collective problems.

57<http://survivingwork.org/top-tips/top-tip-1-how-to-restore-your-humanity/>

58<https://theconversation.com/columns/elizabeth-cotton-154998>

59<https://www.gov.uk/government/publications/the-nhs-constitution-for-england>

60<https://www.gov.uk/government/consultations/statutory-duty-of-candour-for-health-and-adult-social-care-providers>

61<http://ww4.midstaffsinquiry.com>

62<https://theconversation.com/nhs-guardians-wont-help-whistleblowers-unless-theyre-protected-from-bullying-too-37543>

63https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403010/culture-change-nhs.pdf

Candour in a context of austerity

The most common concerns in health and social care relate to connected issues of changes in service delivery such as outsourcing, work intensification, staff shortages and insufficient skills mix⁶⁴.

In a context of austerity one of the difficult areas for staff is whether to raise concerns over a lack of resources. Professional codes advise that if you know that there is a serious problem with lack of resources and prioritising them then you are obliged to raise your concerns. In this situation, the clinician is personally accountable for following their professional code and obliged to refuse instructions on the basis of their duty of care.

For health and social care professionals, the duty of care could mean refusing an instruction where you believe they have been expected to breach their professional code. This puts health and social care workers in, at best, a political position and at worst an impossible one.

The new regulations on our duty of candour⁶⁵, although well meant, add a further nail to the transparency coffin - making the focus on establishing the crime and the punishment, rather than the pressing problem how to tackle the culture of fear that they work within.

The Francis inquiry shows that where bullying⁶⁶ and racism⁶⁷ exist mistakes really happen. If our response is to regulate and punish alone, we are just setting up a system where silence is institutionalised. Only martyrs need apply.

Our duty of care to each other

One of the problems with the current marketized⁶⁸ and legalised model of care is that it creates splits - between colleagues and between staff and patients.

In this highly politicised health care system the duty of care debate is dominated by the clinician's responsibilities to their patients. This is not to suggest that patients aren't at the heart of the NHS but to do this at the expense of the other duties involved in care has turned out to be a disaster.

64<http://www.theguardian.com/healthcare-network/2013/may/28/guarantee-healthcare-workers-duty-of-care>

65<https://www.gov.uk/government/consultations/statutory-duty-of-candour-for-health-and-adult-social-care-providers>

66<https://theconversation.com/heres-how-to-deal-with-bullying-in-the-nhs-48471>

67<https://theconversation.com/why-black-working-lives-matter-in-the-nhs-49168>

68<https://www.oneworld-publications.com/nhs#.Viy50emSNFI>

If you ignore the NHS's duty of care to the people that work for it so that 30% live on less than a living wage then you can argue that the NHS is failing in its duty to provide quality care.

The announcement of a £5 million occupational health fund for NHS staff - in response to burnout and long term sickness - indicates that many of us are failing in our duty of care to ourselves. Our duty to work in a way where our own health is protected.

The establishment of a 'pervasive culture of fear' where people are unwilling to raise their concerns about patient safety also indicates a total failure of our duty of care to each other working in health and education. Our relationships with each other not sufficiently strong to risk speaking up at work. Many of us cope with working in the NHS by shutting up and actually not caring very much about the people we work with.

The reality is that if we are to improve clinical practice staff have to be able to form relationships that are strong enough to manage difficult conversations about the mistakes and unfair choices that are inherent in the job.

A relational model of care

Given the emotional nature of the work of care, you'd think we'd all be experts in forming relationships. But most working people cope with conflict and group dynamics by withdrawing into a '[bunker](#)'⁶⁹ - a safe place not disturbed by actual other people.

Drawing on the psychoanalytic concept of '[working Intimacy](#)'⁷⁰, developed by a practitioner Angela Eden, is really helpful here.

Within this relational model of work, providing good care involves three things: putting the job of work back in centre place and then agreeing some common principles that set the battle lines between what's fair and what is not. Because our principles in health and social care are compromised every day, these two elements can only be protected if we have genuine and functioning relationships with the people we work with. The third element of working intimacy is therefore that we have to get on with having actual relationships with the people we work with.

One of the difficulties of getting on with people at work is that for many of us working in health and social care we've got superegos like tanks - the internal voice that sees things in absolutes of right and wrong, black and right - you-must-do-this rather than what-is-

69<https://www.routledge.com/products/9780415099233>

70http://www.edenevolution.co.uk/research_publications.html

realistic. It means that on an internal level, giving good care means challenging our internal Judge Judy and the part of us that wants to blame and shame others more than we want to understand them.

In this relational model, our capacity to deliver care and its associated duties rest entirely on us having relationships at work where mistakes can be made, thought about and addressed without anyone being burned at the stake.

Surviving work in health and social care

For many of us working in the public sector our relationship with work is abusive, working without reward or a sense of belonging and taking the blame for someone else's actions. Materially and emotionally, the more vulnerable our own situation becomes the harder it gets to care compassionately about others.

The over-emphasis on what needs to be delivered for less money comes at the expense of doing this. This political deficit means that a central task for all of us, whether patients or clinicians is to take a position on the values that underpin the NHS and to defend them.

This is both a political and concrete task. To defend a principle of care that is fair both to patients and staff, and to build sufficiently intimate relationships where we can work responsively rather than defensively.

Ultimately, surviving work depends on how we treat each other. It matters if you ask people how they are and listen to the answer, support someone with a concern at the next supervision or join a union. Time to dig deep.

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Survival Surgeries: Working on the Healthcare Frontline

Whether you're a self-employed therapist or a nurse working in old age care, Survival Surgeries are a simple way for you to build your capacity to address workplace problems. This model has been developed by Surviving Work, working with health workers in diverse settings, based on the principles of adult education using tried and tested activities that have brought about real change in workplaces all over the world.

These methods can be used in formal and informal meetings, workshops and group events wherever workers want to develop an agenda for change.

Survival Surgeries follow three core steps described as the **LAUGH** approach:

Stage 1: Starting where you are by **L**istening and **A**ssessing what is actually going on at work

Stage 2: **U**nderstanding your environment and identifying resources that you individually and collectively have

Stage 3: **G**etting **H**elp from the people around you and collectively solving problems

The model always involves these three stages of establishing what the real problems are, getting more information and collective planning.

Getting started

How you start very much depends on your working environment. It may be that you are part of an existing group or team that wants to try this model for managing discussions. If you want to establish a group yourself you can do this as part of a professional

development, team-building, supervisory or social activity. Surgeries can be described in any way you think will work in getting people to join - from book clubs to reflective groups - use whatever language you think people will be receptive to. People tend to find it easier to attend a more technical learning group - such as discussing new policy or research - but the key is to develop a safe and containing space where people can say what they think.

On a pragmatic note, often if you ask your workplace for permission to start a new 'project' the answer will be 'no'. You do not need permission to set up an informal group or safe space for the people you work with. In fact it is worth having a go at setting up a space informally a few times before going public with what you want to do. Much easier to get people to sign up to something that already exists, and much harder to block it too.

It is useful to start with two or more people who are driving the process, securing participation and facilitating the initial Survival Surgeries. Over time you will build up capacity for members to rotate facilitation and people will emerge who want to run sessions. When you're starting a group it is often easier to start small with regular meetings, usually with monthly or six week gaps.

Because of the likelihood that issues of conflict and anger will arise in surgeries you need to set some clear ground rules for discussion. These are:

- confidentiality of content
- anonymising workplace issues to reduce scapegoating
- respect and equality of everyone's experience
- voluntary attendance but a commitment to attend regularly
- no lectures, posturing or power points

You will also have to think about whether you invite managers and supervisors to your

surgeries. This is a judgement call that you should think carefully about - whether their participation will help or hinder collective action and dialogue within the group.

Survival Surgery

Following the three LAUGH stages, here are three activities that you can use to run a Survival Surgery. This sample session can take 2-3 hours, about the length of a staff meeting and a time frame that people can generally commit to. Group size can vary from roughly 8-30 - even larger if you're comfortable but if you're starting a new group around 15 people is ideal.

Set your Ground Rules: just introduce your ground rules, it helps if you write up on a flip chart.

Activity 1: Listening swap (30-45 minutes)

Ask participants to work in pairs, preferably with someone they don't really know. One person will be the speaker, speaking for 5 minutes about what is on their mind with the listener just listening. No prompting, questions or normalising, just listening. After five minutes ask people to swap round.

The more open you leave this the better but you might want to focus this activity using an open question such as "What is the real issue you're facing at work today?".

Depending on the size of the group you can ask participants to say what came up in the Listening Swap and write these down on a flip chart. The issues raised here become the focus of the discussions during the Survival Surgery.

If you are working with a larger group (over 20) you can ask people to work in groups of 5 or 6 to discuss the key themes that came up for 15 minutes and then have a whole group

discussion (15 minutes).

Activity 2: Understanding workplace issues (30 minutes)

You can do this activity as one group if you have less than 15 members. If you are working in a larger group, ask people to work in small groups of 5-6 people.

From the previous activity ask if there is a case/issue at work that one of the participants would like to discuss with the group. Normally people are willing but this may take some encouraging noises from the facilitators. This person will spend 5 minutes introducing the problem they are facing at work. It works better if the person speaking uses flip chart paper to draw a map of the issue so that participants can see the issue from an organisational perspective. Participants will then reflect back what struck them about the case and collectively identify what the issues behind the case are.

Small groups should be asked to write on a flip chart the issues that emerge from this discussion - in a larger group you as the facilitator should summarise the issues around the case. You can take a five minute break here if needed.

Activity 3: Collective Problem Solving (30 minutes)

Continuing with this case study, ask people to work in groups of 3-5 people to identify three or more actions that could be taken to address the issues raised. It is important here to work in smaller groups to allow for a real exchange of people's experiences. It can help to focus discussions to ask people to come up with three things that could be done but obviously if people have more then try to capture them. After 20 minutes, ask each group to report back on their proposed lines of action with the facilitator writing these on a flip chart. The next stage is a whole group discussion to identify the actions that the

participants think are realistic and can be committed to both in the short and long term.

Whatever is agreed by the group during this activity is the plan of action for the group so if the usual suspects end up with all the tasks allocated to them then you will need to address that in the group. At each subsequent surgery it is important to review the plan of action and discuss any issues that arise (loads) since the last surgery. You can do this using an amended version of Activity 2.

Summarise the Survival Surgery: Normally you will use the last 15 minutes to review what has been agreed and set the date for the next Survival Surgery.

Why it works

These are highly effective methods that in a short period can help organise collective responses to workplace problems. Having a clear three-stage model and activities to guide discussions can be containing for participants who are often anxious about talking about difficulties at work for the first time. Dialogic methods are really effective in building relationships with the people we work with - based on real understanding and an appreciation of other people's experiences. The focus on collective problem solving at the end of each surgery focusses participants on the real job of work ahead and our collective responsibilities for bringing about change.

Surgeries do not have to go on forever - they often work for six months after which the focus can drift. This is not a failure, if relationships within the group have been strengthened. The main thing is to keep the energy and pace of the group for as long as people feel it is useful. Surgeries can also shift in their focus and membership - again, as long as it is responsive to what people actually want this is a good thing. Surgeries work if they are useful, so the key is to respond to the needs that come up rather than to stick to the original plan.

Working with group dynamics

Health workers are experienced at dealing with anger and distress but most of us feel a lot more about problems at work than we normally express and if a Survival Surgery is going well, people will raise difficult issues. If participants become angry or distressed during discussions it is important to acknowledge this and allow the group to process strong emotions and the issues that trigger them.

The following is a simple process of containment that you can use to manage your own or other people's overwhelming feelings, either in Survival Surgeries or more broadly at work.

First aid provides some very simple and immediate steps to contain overwhelming feelings - you can use five steps we are calling **CABIN** (nice mental picture of a safe place in a wood, birds and Bambi).

CABIN

Contain: remove yourself from whatever is making you anxious and find somewhere where you feel safe. If you can, call a friend or find someone at work you trust to help you.

Acknowledge: don't try to ignore what has just happened and acknowledge the anxiety.

Body: try to control your breathing, lengthening your breath and, if it helps, count one-two-three slowly in your head. Keep going until your breathing has normalized. If you're around someone you actually like ask them to give you a hug or merely a little squeeze. Human contact really works.

Identify: work out what you are worried about right now. The immediate real source of the anxiety rather than the nameless dread that sometimes creeps up on us

Next steps: work out what the next steps should be. Find at least one concrete thing that you're going to do right now to make sure the fear doesn't pop back. This stage is always better if you can find a friend to do this with.

If you do one thing

It may not be that you're able to run a surgery right away. But you can use these activities in your meetings and working life to stimulate a real discussion with the people you work with. If you do one thing, start each discussion or meeting with colleagues asking what is on their mind and genuinely listening to the answer.

Survival Resources

- Free online resources about how to survive working in healthcare

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