**The future of mental health services: the organising challenge ahead**
**Elizabeth Cotton**

This instalment of the Soundings Futures series grapples with the current crisis facing the UK's mental health services

Despite the cultural shift in our appetite for thinking about mental health issues in the UK, and all the recent debates about mental health, we are still failing to protect either the services or the people who deliver them. The aim of this article is therefore to open up an inclusive debate within the sector about what constitutes a quality mental health service, and to consider how we could organise around this agenda.[1]

One central reason for current problems is the overwhelming focus of the service on Increased Access to Psychological Therapies (IAPT), the NHS's largest mental health programme. IAPT has been offered as a silver bullet to the mental health crisis, but a central part of my argument here is that, on the contrary, IAPT has been a main driver of the unfolding crisis. As a direct result of its faults, mental health services are facing a workforce and political crisis - though this remains largely hidden from public view. A key aim of this article, therefore, is to draw attention to the extremely serious effects of this programme - effects that are directly connected to the wider neoliberal mindset that frames it.

Getting a clear picture on the state of mental health services can be difficult, as there are some apparent paradoxes in the public mental health research - which in themselves raise important questions about how mental health is measured, and the need to contextualise and analyse data. Indeed, approaches to data collection, and the way data is used, are a central part of the debate.

Information on the demand for mental health services is patchy, but it has been estimated that the demand for mental health services will have gone up by two million by 2030 - in addition to the 1.8 million people currently accessing services in 2015/16.[2] The government's ONS Wellbeing measurement, however, reports a steady increase in wellbeing - but this data cuts against most other indices of mental health, including the rise in suicides, and the growing research that links socioeconomic inequalities to health inequalities.[3] According to the recent Darzi Review of Health and Care, there has been an increase in mental health problems in the UK, particularly among children, where an estimated one in five experience mental health problems.[4] Pockets of chronic un-care have also emerged in relation to Child and Adolescent Mental Health Services (CAMHS), and acute and postnatal mental health services.

The total amount spent on mental health is unknown. Most public funding is directed at NHS England, which then allocates funding to Clinical Commissioning Groups. The Sustainability and Transformation Fund - now the Provider Sustainability Fund - was established in 2016 to provide £1.8 billion additional funding for NHS services, as a government response to public concerns about the under-funding of services. But it is estimated that it has only contributed a 1.4 per cent budget increase to mental health trusts.[5] One difficulty in estimating amounts spent on mental health is that there is very limited information or monitoring of the private providers commissioned by Clinical Commissioning Groups - estimated at 15,000 contracts in 2015.[6]

This article concludes with a discussion on how to challenge the current system. One way is to campaign for an inclusive inquiry into the IAPT model and the nature of the 'evidence base' for mental health services (an inquiry that would not be led by the organisations and bodies with a vested interest in delivering services). Another is to find ways of campaigning more broadly for better mental health provision. I therefore also discuss the potential for developing a new negotiating platform to address workforce issues in the service, including wages, working conditions and standards of care needed for a quality mental health service. Again, the proposal is to establish a body that is not populated by employers' organisations or private providers, but by the professional, trade union, service-user and political networks that have an interest in mobilising mental health workers to defend services.

**What is wrong with IAPT?**

> The [IAPT] role is high-volume low-intensity, just churn them out. It's viewed as an unskilled job. The managers would say don't take on counsellors in this role because they are just trouble and not prepared to do tick-box services. It's an uncomfortable dynamic with the young psychological wellbeing practitioners (PWPs) straight from universities, who are naively prepared to do as required by the service. In reality most of our patients have lots of life problems - we work in a really deprived area, lots of housing and drugs problems and severe depression and anxiety. That's kind of ignored by the service providers because they have to answer to their commissioning group. There's a big gap between the data and the reality of what we're trying to do.
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The Increased Access to Psychological Therapies programme provides short-term results-oriented cognitive and behavioural therapy, and has been introduced as a 'talking therapy' that efficiently addresses individual psychological states. The 'evidence base' for its effectiveness has been established through the widespread use of performance data, drawn from a system that has itself become highly contested - in terms both of the relevance of what it measures (such as waiting times) and of the accuracy of its claims (such as a 50 per cent recovery rate). The IAPT model is based on a system of patient assessments that uses tightly scripted questionnaires that allow only minimal freedom of discussion between therapist and patient. Though most service users have complex needs, the superficiality of the assessment and performance-data collection process allows clinicians to refer them to short-term interventions that are not, for example, designed to treat depression, and to make claims about recovery that do not relate to the mental health problems that service users are actually living with.

Because of the relative low cost of IAPT services, in comparison to the long-term talking therapies and specialist services that require experienced clinicians, the economic argument for rolling out IAPT services has prevailed across the UK's mental health policy. Although, as campaigners legitimately argue, the financial case made for IAPT has excluded any consideration of the real costs to the UK economy of not treating mental illness adequately - including consequent costs to acute services, police and prison services - the direct costs of IAPT have dominated the debates about how to provide mental health services. As a result, despite the genuine concerns about the ethics and quality of care being provided through IAPT that have been expressed

by service users, particularly the many disability and mental health networks in the UK, this downgraded model of 'talking therapy' now dominates across the UK's mental health service. The economic logic for providing mental health services now dominates over any clinical logic.

IAPT is also a central part of the political crisis that is emerging for mental health services as a result of its positioning as a key component within the government's austerity programme and its plans for changes to welfare benefits. There has been a merging of mental health services with the DWP's programme of welfare reform, as outlined in the DWP's 2017 green paper *Improving Lives: the Future of Work, Health and Disability*, and the establishment of the Work and Health Programme, which has replaced the Work Programme.[7] For the first time, health and unemployment services in the UK have been explicitly linked. The adoption of the IAPT model has been central to these plans, since it is cheap to administer, and people who are 'cured' are then disqualified from benefits based on the state of their mental health. This is in part a response to a growth in the proportion of Employment Support Allowance (ESA) claimants (the benefit that replaced incapacity benefits) who experience mental health problems. This rose from 37.3 per cent in 2010 to 49.3 in 2016, when ESA claimants numbered 1,178564.[8] A primary target for reducing the benefit bill is to ensure the return to work of people living with mental health problems.

In order to implement this reform (which is also closely associated with the introduction of universal credit), the DWP and Department of Health have created a series of 'pilot' programmes and partnerships between Jobcentre Plus, Work Programme and IAPT services. In 2014, the introduction of Jobcentre staff and employment support workers into IAPT services took place, and there was an initial pilot programme to introduce IAPT services into Job Centres. This was met with strong rejection from mental health activists, despite the initial engagement of five of the large psychotherapeutic professional bodies in establishing this new area of work. The programme has nevertheless been rolled out regionally, and has involved the carrying out of 'wellbeing' workshops for claimants, and 'psychoeducation' group-work to encourage job applications and skills to secure employment.

At the core of this policy is the introduction of the new 'fitness for work' welfare assessment process (where fitness for work, rather than extent of disability, is measured). The process targets claimants with Personal Independence Plans (PIP), or who receive Employment Support Allowance or disability living allowance. This has resulted in a dramatic decline - by an estimated number of 2 million claimants - for these schemes since austerity measures were introduced in 2008 - either through claimants being declared fit-for-work or through claims being withdrawn.

It is very clearly understood by claimants who have 'volunteered' for these programmes that the way it links work and mental health raises ethical concerns about confidentiality, the therapeutic relationship and professional conduct. And one of the implications for mental health workers of this re-orientation of mental health services has been that it has created a significant credibility risk for the sector and for the people working within it. The deployment of the IAPT model as part of a strategy for delivering welfare cuts has raised profound ethical and professional concerns for workers.[9]

Indeed, one result of the entanglement of mental health with welfare reform designed to exclude people from benefits, and the weakness of the IAPT model, has been that, despite the acknowledged attack on mental health services from a decade of austerity, there is an ambivalence within the service about government attempts to increase mental health funding by rolling out the current IAPT model. For many people working in and accessing these services, IAPT is considered a threat rather than an expansion of decent care. All this raises a profound question about what kind of services we should be spending money on.

A further strategic objective of IAPT has been that is an enabler of the opening up of the mental health sector to private, third sector and non-clinical providers. This is partly because it paves the way towards a downgrading of clinical roles and jobs across the mental health sector. The delivery of the new welfare programmes has been carried out almost exclusively by large private contractors, including Maximus and Atos, and the majority of assessments have been carried out by staff who are not clinically trained. The 'new' mental health jobs created in these programmes do not require clinicians, and the whole process therefore represents a clear move towards generic and non-clinical jobs in the sector. The manualised and online nature of much of IAPT's interventions also opens the door to digital providers. Much is now being made of digital healthcare, including grand claims for digiceuticals and the use of App technologies to measure health levels, including mental health. These have been supported by successive health ministries. The benefits of this tech 'alternative' to complex long-term treatments provided by clinicians are clearly empirically exaggerated, but they are heavily supported by the normative logic of austerity on which decisions about mental health are actually based.

Despite a number of recent mental health inquiries and workforce reviews, there has yet to be any genuine engagement with the emerging crisis in the sector. It may be that one explanation as to why the expansion of IAPT services has not been subject to public inquiry is the vested interests of the individuals and organisations involved in the reviews (for a selection see below). Given the almost universal criticism of the direction of mental health services on the part of clinicians and service users, the question has to be asked: who benefits from the uncritical continuation and expansion of the IAPT model?

**The policy framework**

One striking characteristic of the mental health sector is the limitations of the policy frameworks within which it operates. Current policy for mental health is primarily expressed in *The Five Year Forward View for Mental Health* (FYFVMH), produced in 2016 by the Mental Health Taskforce (led by Paul Farmer, CEO of Mind, the largest mental health charity in the UK). As with many mental health policy documents, the principles behind it are relatively progressive. It has a psychosocial understanding of mental illness, and is supportive of co-production with service users, patient-centred services, collaborative approaches and workforce planning. But it pays no attention to the major barriers to providing good care. And it takes as self-evident two key assumptions: the efficacy of the IAPT model and the financial logic that underpins it. This means that, although the report recognises the deficit in reliable data, and the complexities of addressing mental health through coordinated health, housing and welfare systems, it nevertheless accepts the financial logic of expanding mental health services to facilitate the DWP's welfare reforms. Furthermore, as part

of this financial logic, it proposes the rolling out of performance-related pay on the basis of outcomes - presumably based on recovery targets and getting patients off benefits - while leaving the actual workforce crisis untouched.

The FYFVMH implementation plan, produced in 2018, nods towards improving the data behind a new mental health workforce development strategy by setting up the Mental Health Services data set, but this only serves to further expose the weakness of the NHS's existing workforce strategy. The proposed expansion of services relies on systemic de-professionalisation. Although it acknowledges staff shortages and a failure to recruit the next generation of clinicians into clinical training, it does not address the growing gap between training and professional registration requirements, or the clinical requirements of jobs in mental health. To add insult to injury, the report proposes to address the wellbeing of mental health staff through a 'lite' programme of stress management, phone therapy and mindfulness.

A second important policy document is *Stepping forward to 2020/21: The mental health workforce plan for England*, published quietly in July 2017 before the summer break, and with no debate or consultation. It is unclear what, if any, consultation over this document took place, and the strategy contains some important omissions on implementation. It seductively proposes 21,000 new mental health posts by 2021, to cover the 10 per cent staffing shortage being experienced across the sector, which is particularly acute in nursing and psychiatry. However, although it proposes that a substantial number of these new positions - 11,000 - will be clinical, including those in regulated professions, 8000 will be made up of non-clinical associate roles and others by non-waged peer support. In other words, 50 per cent of future roles will be non-clinical. This expansion of non-clinical roles is, in part, justified as an 'alignment' of job functions with the new model of short term, non-clinical mental health interventions being introduced through IAPT, and the wellbeing programmes being introduced in primary care. This means that the implementation of the government's mental health strategy is fundamentally underpinned by the downgrading of jobs in the sector.

The Lord Darzi Report, produced in 2018, also looks at mental health provision. It accepts the growth of inequalities as an important contextualising factor, and acknowledges Marmot's social health agenda, but again fails to address the real barriers to improving mental health levels in the UK. As with all previous policy documents and reviews, the 'quality' of IAPT services and recovery rates is not questioned. Indeed the report absurdly claims that mental health services have improved in quality since the introduction of IAPT. The report also pushes for the opening up of the mental health market in response to the 'over-regulation' within the sector, a claim that has been strongly contested in relation to private providers - who are not routinely monitored.[10] The panel responsible for producing this report included representatives of Gilead Sciences (a private biopharma company), and Siemens Healthcare.

*Thriving at Work: The Stevenson/Farmer review* is a recent high-profile report on the growing wellbeing at work industry, regarded as an increasingly important part of the wider mental health field. The review outlines a set of core standards for wellbeing at work that represent an uncontested and research-based set of recommendations, including better people management, 'good' working conditions, mental health

awareness and support. However the review suffers from a politically naive formulation of 'good' work, and is not informed by any of the employment relations research about institutional models; it is apparently unaware of problems such as the growth of precarious work, and maintains the assumption that any work is good for you. It is overwhelmingly based on the financial rationale of reducing sickness absence. Its proposed model of wellbeing at work is painfully uncritical of the current dominant mental health model - which, like IAPT, focuses on individual cognitions and behaviours; and it uncritically accepts employers' programmes for managing wellbeing, particularly mindfulness programmes, whose impact has been highly contested. This is a policy without a hope of changing existing practice. It should be noted that Mind's Paul Farmer was also co-author of this report, and that MIND is emerging as a major provider of wellbeing services, both within the DWP but also commercially in relation to workplace wellbeing programmes.[11]

**The strategic role of performance management**

A wider context for health policy (and for the public sector more widely) is the New Public Management that was introduced across the public services in the UK in the 1980s as part of the shift towards introducing competition and privatisation into the sector. More recently, this logic has been reinforced by 'austerity logic', introduced in the period following the financial crisis in 2008 in an attempt to address the tension between budgets and clinical priorities.[12] The New Public Management introduced a 'results-oriented' culture, and for this a performance management regime was needed in order to focus attention on reaching targets. Performance management has thus been a key mechanism for the reform of mental health services - and more recently for the introduction of the IAPT model

New Management has gone alongside a programme of quasi-market 'modernisation' in healthcare: the decentralisation of commissioning and service planning has been in place since the late 1990s and is enshrined in the 2012 Health and Social Care Act. Privatisation has been encouraged through the introduction of 'any qualified provider' tendering processes - driven by the neoliberal idea that services can be run more efficiently by introducing competition, and breaking up monopolistic public-sector organisations into business units. This has involved a rapid decentralisation of decision-making right across the NHS, with the introduction of new localised structures at commissioning and contracting levels. There has been a mix of both centralising and decentralising tendencies within the NHS. There has been an increase in management control by virtue of its enhanced operational discretion, including in shaping the employment relationships; but there has also been an increased role for government in setting performance targets and performance data mechanisms, and in wider systems of auditing and regulation.

The Health and Social Care Act was also part of the austerity programme: it sought to reduce management costs by 45 per cent.[13] The impact of these cuts has been complex, but it has included a reduction in management jobs, which has in turn led to the 'transformation' of clinical roles to cover frontline management functions, a move that further embodies the tension between financial and clinical logics.[14]

In the context of austerity, performance management has also become an ideological and moral approach to managing public resources, as a response to 'irresponsible' overspending in the public sector.[15] Performance data and management have been

widely used to ‘evidence’ the value of public spending, and this has had the effect of narrowing the debate so that it becomes one about market efficiencies, rather than questions of quality care or meeting needs.[16] Additionally, the model of performance measurement has greatly increased the bureaucratic workload within the NHS: management has increasingly become more a question of box-ticking, rather than an effort to base decision-making on a real understanding of performance within the organisation.

The targets and measurements on which performance is measured in the NHS have led to some dysfunctional consequences, including misplaced incentives and sanctions that can undermine quality care.[17] That is, performance measurements may not lead to improved performance, because of a potential ‘performance paradox’, where data does not capture either the strengths or weaknesses of the care system.[18] For example, in the case of mental health, the way that recovery outcomes are formulated assumes a linear process of change and recovery, a far cry from the dynamic and complex experiences of patients engaged in the talking therapies.

A further problem has been the NHS use of an inclusive measurement of quality of care - that is, it looks at quality of care alongside access to and cost of care. This combination of the three factors evades the tension between them: the question of whether increased access can be achieved with quality of care. The IAPT programme was set up precisely to increase access, at a low cost. It offers 4 to 12 sessions of cognitive and behavioural interventions, and can be provided by non-clinically trained staff. It is clearly therefore a relative cheap option, but, as we have seen, there have been concerns raised about the way that IAPT service outputs are measured, including waiting times, recovery rates and re-admissions.

The way in which IAPT has been set up fits perfectly with a preoccupation with financial targets and performance indicators that reflect efficiency within the service rather than clinical outcomes.[19] Financial concerns underpin the ‘evidence base’ for IAPT interventions, and these are made up of rigid performance data measurements (such as those noted above that claim that services offer a 50 per cent recovery rate for patients).

Arguments for the effectiveness of the IAPT model now dominate policy decisions across mental health services; and the use of performance data has also been adopted for services outside of the IAPT programme, in order to provide ‘evidence’ of their value for money, and to secure funding and contracts. Clinicians consistently raise concerns about the ethics of the IAPT model, but the dominance of the IAPT performance data regime means that providers are forced to adopt these measurements in order to secure NHS contracts and continue to provide services.

One of the under-articulated consequences of this centrally defined model of performance data collection is the problem of gaming, such that organisations are forced to misrepresent outputs in order to achieve performance targets. The emergence of gaming as an ‘alternative logic’ within the NHS is one of the most serious problems with the current performance management system.[20] Although there may be a distinction between a deliberate misrepresentation of performance and reporting data using an inadequate measurement, the results may be equivalent. In addition to misrepresenting the efficiency of services, the gaming of data can also lead

to a lack of engagement with the consequences of poor services, such as suicide rates. Using the current measurements, it is quite possible for a service to be considered highly performing in terms of waiting times and discharging patients, as reflected in CQC audits, but at the same time to have serious problems with patient safety.[21] In response to such problems, in 2017 the National Audit Office carried out an inquiry into the performance data of IAPT, specifically the measurement of waiting times and the claimed 50 per cent recovery rate. The report was not published, however, despite a high level of submissions raising their concerns from people working and researching in the sector. Despite repeated FOI requests no explanation for this decision has been given. It appears that there is little appetite to publicly inquire into the evidence base of the current mental health model.

A further consequence of the dominance of this model of performance management has been the establishment of a 'command and control' management culture. Research indicates that managers under pressure to deliver targets typically default to a command and control style, and become insensitive and defensive, putting a downward pressure on quality of care. This in turn is linked to the emergence of a culture of bullying within the sector, with staff reluctant to raise concerns for fear of victimisation - a concern that has been reinforced by the treatment of NHS whistleblowers.[22] This management culture has led to a widespread silencing of staff, both within mental health services and more broadly in healthcare - and also to the establishment of the Freedom to Speak Up initiative, by the National Guardian's Office.

**The conservatism of the professional framework**

In stark contrast to the competitive world of new public management, the major professional and training bodies have acted as a conservative force in their role of maintaining the current system of training and professional registration within the sector. There continues to be an over-supply of psychological and psychotherapeutic training, and the number of people being trained in long-term mental health qualifications has no apparent relationship to the availability of paid employment. Within mental health services approximately 45 per cent of workers will come from a mental health nursing background, but many will also have undertaken Continuing Professional Development and further training, often in counselling and psychodynamic trainings. The vast majority of psychotherapeutic trainings are self-funded, as, increasingly, are clinical psychology trainings. Despite the decline in decent jobs, the training industry continues to be robust, and it is increasingly directed towards attracting international students, and promoting a model of post-qualification working life in private practice.

The work of the child psychotherapists offers one exception to this professional landscape: some years ago they managed to secure NHS recognition and funding for their training. Although the number of trainees in the UK remains small, at around thirty students per year (mainly trained through the Tavistock and Portman clinic and the Northern School of Child and Adolescent Psychotherapy), most trainees go into CAMHS, although some will now find work in schools. Currently, clinical roles in CAMHS are likely to be held by trained child psychotherapists, but as the funding stream is cut it is likely that these roles will be downgraded, as in adult services.

The gap between institutional training and support and the real needs of graduates in securing full-time and paid employment remains large. Universities providing clinical training have not explicitly addressed the decline in employability in the mental health sector; while the independent training bodies have not addressed the decline in UK students who can afford lengthy trainings involving years of unwaged work (apart from in the marketing of courses to international students or offering specialist and CPD courses). Moreover, critical debates about the downgrading of work and the lack of paid work are not encouraged within these institutions, for fear of raising systemic and potentially unsolvable problems within the training model.

The professional and training bodies continue to offer the same model of professional training and development that has essentially been in place for the last twenty years. The issue of the costs of training, and the levels of honorary work involved in completing training and professional registration, is, however, the subject of an emerging internal debate, and some bodies, such as the UK Council for Psychotherapy and British Association for Counselling and Psychotherapy, are attempting to develop policies around unwaged work. However, there is no radical agenda for change in response to the widespread downgrading of mental health jobs. Professional bodies attempt to contain debates within professional silos, and are reluctant to take a broader perspective on jobs in the mental health sector as a whole. Students consistently demand greater preparation for waged work and support in finding clients in private practice from these bodies, but, as with other insecure sectors - such as the creative industries - the realities of working life are not fully addressed at an institutional level. The realities of securing paid employment with potential for progression and setting up in private practice - the main alternative to waged work - are only superficially addressed during training. This helps to obscure the financial reality that, for newly qualified mental health workers, self-employment offers a bleak prospect for earning a living wage.

This absence of action on the part of the psychological and psychotherapeutic professional bodies is related to the internal tension between their roles: they function both as regulators and gatekeepers of mental health work and as membership organisations to defend workers' interests. None so far has taken a lead in coordinating the many organisations involved in representing mental health workers to establish a platform to negotiate wages and working conditions more broadly across the sector. Further, they have not attempted to challenge the IAPT model, but instead signed a profoundly ill-advised memorandum of understanding with the DWP about the introduction of psychological therapies into job centres. This has subsequently been buried, but it has added a further significant disincentive for them to open up a debate with their members about therapeutic modalities. Within most of these organisations there exist outspoken individuals and networks that make important challenges to their institutions; and there is a growing acceptance by members that the protection of their professions will involve opening up to difficult debates about money and jobs. Although this dissent is patchy, there is potential here for the professional bodies to contribute towards reform in the sector, an issue to which we return to in the last section of this article.

**The composition of the workforce: the Surviving Work Survey**

One of the reasons that the recent profound decline in mental health services is so absent from public debates is the lack of data about the workforce, wages and

working conditions. Such data as does exist is for workers directly employed by the NHS, but, given that an estimated 30 per cent of mental health services are provided by private and third-sector providers, and that an estimated 30 per cent of workers in the sector are on self-employed contracts (these two categories overlap but do not coincide), this only gives us a partial picture of what is actually happening in services. This lack of data about the decline in wages and working conditions is compounded by the reluctance of staff to talk about their working conditions, in part because of insecurity but also fear of victimisation (the latter is also affecting clinicians).

Three overlapping but different head counts are provided by NHS Digital: NHS Staff with selected mental health occupation codes - 165,014 workers; Fixed Term Temporary NHS Staff - 114,627 workers; and NHS Staff in Mental Health and Learning Disability Trusts - 188,952 workers. The NHS data also gives a breakdown of occupational groups. For mental health trusts, 33 per cent (the largest group) are workers supporting clinical staff; 31 per cent are nurses; 16 per cent are 'infrastructure support' (including managers, and non-clinical workers in 'hotel, property and estates'); 15 per cent are members of qualified Support and Treatment Teams (including therapists); and 5 per cent are doctors. There has been a rise in the number of psychotherapists within the NHS, but, more significantly, there has been a growth in psychotherapeutic jobs, although many of these jobs are in the third and private sectors, and much of the work is part-time and on the basis of self-employed contracts.[23]

There is no workforce data or monitoring of working conditions for those working for non-NHS providers.[24] And it is in this kind of employment that staff are most likely to be affected by the increasing trend towards precarious employment - though self-employment is also a source of precarity in other parts of the workforce.

Partly in response to this lack of data, during 2016-17 I was involved, along with Professors John Grahl and Ahmet Suerdem, in carrying out a Surviving Work Survey, to try to get a better picture of working conditions across the mental health sector. Our results indicated that, although it is true to say that working life in mental health is diverse - with teams and individuals trying to build sustainable services everywhere and with many experienced clinicians being able to influence how work is done - most of trends we identified are uniform across the UK.[25]

Our survey showed a clear trend towards precarious work. A growing majority of people were working in multiple settings using different modalities, increasingly providing generic rather than specialist care. Although 74 per cent of respondents said they worked for the NHS, many reported that they worked on short-term contracts, and many were working for multiple employers, as direct employees of third-sector or private providers, or as self-employed workers contracted to these providers. In fact it emerged that people were often confused about who they worked for and what their employers' responsibilities were. On being asked who their employer was, only 20 per cent said they were self-employed, but when asked what kind of contract of employment they had, the figure rose to 30 per cent. A further 8 per cent of respondents did not know what kind of contract they had, and 8 per cent had no written contract at all.

13 per cent of survey respondents worked for IAPT, and 23 per cent within IAPT services. Many more had moved in and out of IAPT services, and most of our respondents felt that they were working under the IAPT model. A surprisingly high number of people - 20 per cent - worked in IAPT services as honoraries, as part of their clinical training.

Because of the nature of flexible work, respondents were stretched across a range of services; 22 per cent of NHS workers had multiple employers. Part-time work was also significant: 29 per cent of respondents worked part-time. Of these, 59 per cent worked in the NHS and 38 per cent were self-employed. Many respondents reported that they coped with work intensification by going part-time. Additionally, newly qualified workers and trainees who had set up in private practice reported low patient numbers, resulting in further part-time working practices. Nobody I spoke to from this second group was optimistic that they could earn a living from working in private practice.

Many therapists were earning low wages. 18 per cent of respondents earned less than £300 per week take-home salary, and the average weekly income after tax was between £400 and £500. This is partly explained by the percentage of people working part-time, but it also relates to the widespread use of unwaged work within the sector. Many therapists work unwaged as honoraries, a system of unwaged work that has traditionally been part of most training courses, and is a way of gaining sufficient clinical hours for membership of the psychotherapy and counselling professional bodies. The honoraries in our survey worked across the range of public and private mental health employers, with 50 per cent working in the third sector and 45 per cent in the NHS. A third of them were not trainees but simply worked unwaged, both in the NHS and the third sector. One explanation for this was cuts to funding and the widespread policy of non-replacement of senior roles within services: senior clinicians were continuing to work for free post-retirement in order for services to continue. Our research indicated that 21 per cent of mental health workers work between 1 and 35 hours a week for free, either as part of their training, or registration to professional bodies, or because their service could not offer paid employment. This means the real costs of providing mental health services have been significantly underestimated.

A second trend was towards the downgrading and de-professionalisation of clinical jobs. Given the existence of a gap between qualification and clinical role for many workers, our category of qualification seniority applied to all people registered with a psychotherapeutic professional association, all clinical doctors, and psychoanalysts. Additionally we measured clinical seniority, to include respondents working as psychotherapists, or counsellors with additional roles such as supervision, teaching, acting as clinical/team lead, management, or providing a specialist service. This is a difficult category to allocate because of the downgrading of jobs within the NHS such that the work carried out may be of a high clinical standard but the clinical role itself may not recognise this.

We found that 78 per cent of respondents working in IAPT services had postgraduate clinical qualifications as counsellors, cognitive behavioural therapists and psychotherapists prior to entry into the service, with only 25 per cent receiving in-house IAPT training in High Intensity CBT. We identified that there is a significant

gap between the qualification seniority of IAPT workers and the clinical level of the job they were employed to do, such that 48 per cent of IAPT respondents were working below their clinical qualification levels. A number of IAPT counsellors reported that they would use their psychotherapeutic training and experience to support clients, but as this required going 'off script', they would not acknowledge this within their teams or to management, for fear of reprisals and job loss.

Respondents raised clear concerns about the quality of IAPT services. The principal concern was the decline in number of sessions offered to patients, and the rigidity of the model of CBT that is offered. There was also concern about the number of people working in mental health services with ambiguous clinical status: Psychological Wellbeing Practitioners have been introduced through IAPT to provide manualised short-term interventions and carry out initial phone assessments, but without clarity as to the clinical framework - including training and supervision - within which they should be working. Additionally, respondents reported high case-loads in IAPT services - which ranged between five and eight patients per day - and the consequent problems with work intensification, particularly for more senior staff: it was difficult to find time to complete the performance data forms required by the service.

The issues raised here not part of a nuanced debate about the terms of clinical practice: they express a real concern about patients who are not able or willing to access short-term CBT interventions, and who require long-term and interpersonal work. From a therapeutic perspective, the demands of the IAPT model on both the clinician and patient radically undermine the possibility of establishing a therapeutic relationship that allows for a working-through of underlying issues. Many clinicians regard IAPT as 'sub-therapy'. As a result of these concerns, there was a significantly higher propensity for IAPT workers to raise concerns about working conditions (55 per cent as compared to a sample average of 36 per cent) and patient care (58 per cent as compared to a sample average of 38 per cent).

Our survey also found an age gap: 60 per cent of respondents were older than 47, and 21 per cent were older than 57. Only 19 per cent of respondents were younger than 37. Although many experienced therapists were successfully working in a combination of private practice and NHS work, the demography of the sector indicates that they were only able to earn a living because of having spent most of their working lives in the NHS, leaving their pensions and mortgages intact. A third of respondents said that the best thing they could do to improve their working lives was to retire.

Although it is the case that trainees in psychotherapy and counselling are generally of an older age, and are often in their 40s and 50s, there is a growing concern that there will be a failure to recruit the next generation of mental health workers into training, and to retain them through career progression - which also emerged as an issue.

This split between senior and more junior staff is emerging as a real political block to securing improvements in conditions for workers and for the service. Over the next five years, a senior generation of clinicians will retire, but most will not be replaced by workers at the same senior grade. This means that the clinical and political work of passing on experience and knowledge about how to protect and provide quality mental health services is likely to decline within a relatively short period of time.

**The organising challenge ahead**

Our survey (www.thefutureoftherapy.org) raises a number of questions about how we might influence the way mental health services are delivered in the future. How do mental health workers get to the point of organised industrial activity - a point from where they can make demands about wages and working conditions across the mental health sector? How do we open up a debate within the sector about the political project ahead for defending quality mental health services? And how can we start to organise around this agenda?

Firstly, on a policy level, mental health services deserve a public inquiry into the current regime of performance management and the IAPT model - to be run by a group of people who are not financially invested in the outcome. There is an emerging leadership in the campaign against the IAPT model and the co-option of therapies to deliver welfare cuts - which, unsurprisingly, is led by disability and mental health service user networks. The most radical challenge to the current mental health system has not come from workers or their collective institutions, but rather from disability and mental health networks such as DPAC, NSUN, Recovery in the Bin, Mental Health Resistance Network and the Mental Wealth Alliance. These networks are uniquely placed to provide data and information about what is happening to service users, particularly those on benefits, as well as a critical perspective on the IAPT model. From the perspective of the mental health workforce, critical and outspoken networks exist and will continue to emerge as the crisis deepens.

Secondly, there is a need for the development of a new network of interested parties - including trade unions, service user groups, alternative networks and those professional bodies that have an interest in political action - that can start to research and debate the workforce crisis in mental health services, and work towards creating a platform for negotiation on wages and working conditions in the sector. Many organisations and activists are involved in this data collection, and in raising concerns within the sector. If pooled, this work could be developed to help create a platform for national engagement on the key workforce issues.

Although many mental health workers are members of trade unions - principally Unison, Unite and the RCN, with the addition of a new small union, the Psychotherapy and Counselling Union - there is no clear platform for debating workforce issues within these structures, and none have put forward a response to the expansion of IAPT services, not least because many members are employed by them. However, within all of these structures a critical perspective on IAPT exists, and, if this can be combined with the new networks that are emerging, there is potential for establishing an initial working group to drive the work of the kind of strategic organising and negotiating network we have been describing.

There is an important and growing constituency of self-organised groups of professionals emerging, and these offer a workplace perspective and front-line memberships that will be crucial to any serious strategic response. These currently include Counsellors Together UK, Alliance for Counselling and Psychotherapy, Psychotherapists and Counsellors for Social Responsibility, Free Psychotherapy Network, Critical Mental Health Nurses Network and the Social Work Action Network. There are also some campaigning networks such as Health Campaigns

Together, which offers an umbrella for current NHS campaigns, and Action for Care-worker Wellbeing, which campaigns on workforce issues in health and social care. All of these networks offer important perspectives and support to frontline workers. All have highly experienced and well networked activists within their ranks who could form a key constituency within any negotiating platform.

Whatever constellation of organisations and networks emerges, or puts itself forward to join this platform, there will also be a need to supplement its work with expertise from the employment relations and academic fields. As the recent fallout from the poorly negotiated nurses' pay deal shows, any credible platform has to have the expertise to develop a negotiating strategy that can improve rather than compound existing workforce issues. Combined with the professional and trade union bodies, and capitalising on the Labour Party's recent rethinking of a national mental health policy, a genuine attempt to organise a platform could be set in place.

As experienced campaigners know, the process of creating an inclusive body is a hard one and must be driven by the explicit objective to create inclusivity rather than suppress it. Splitting and territorialism run right through the histories of political and workplace activism and have potential for undermining even the most determined efforts to organise in the sector. As a result the primary principle of any platform must be inclusivity and an openness to new networks and organisations as they inevitably come into existence during the crisis. Without that premise then the debates about mental health will continue to focus on defending an ever decreasing professional circle rather than addressing the strategic downgrading that is actually taking place.

This issue of inclusivity relates to the third and potentially most important line of action which is to find ways of organising at the level of the workplace in order to make sure that services and jobs are protected. Something that stood out in our survey responses was the low number of people who took their workplace problems to a trade union, or to colleagues. Of therapists working outside of the NHS, only 4 per cent had spoken to a colleague about problems at work. The most consistent question I have been asked by mental health workers throughout this research process is whether I know of a group in their local area that they could join to get support. This is in spite of the existence of a range of large trade unions in the sector. Considering that this is a group of people trained to increase relationality, there is a real question about why we seem unable to do this with the people alongside whom we work.

Although the purpose of this article is not to outline methods of solidarity and organising, the way we organise as a sector needs to be addressed in tandem with our development of national policy responses. To do any of this ordinary organising work requires us to challenge the performance management systems within which we work, and, maybe more importantly, to support each other in doing that. This rests entirely on our capacities to build relationships with the people with whom we actually work.[26]

The dual meaning of free association is important here, offering us a way to utilise both our experiences of freedom of association - to collectivise at work - and our abilities in developing deep relationality with the people around us. A relational model of organising is needed, which enables workers to create spaces in which they can seek an understanding of the societal and industrial changes that are taking place,

and to build dialogue and strong solidaristic relationships in situations of industrial conflict - relationships that are able to mobilise members in a context of diminishing resources.

In the 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, and this means there is a need for both a defence of ethical and clinical principles, and for negotiating the conditions under which those principles can survive.

Workplace organising would also benefit from drawing on the emancipatory educational methods of Paulo Freire, which were taken up by some of the workers' education traditions in Western Europe.[27] These methods are based on a framework made up of essentially three connected stages of learning: problem identification; getting information (in particular identifying what resources are available); and planning concrete next steps.[28] Emancipatory education is underpinned by a number of principles, including confidentiality and solidarity, and its activities aim to provide a safe space for expressing and processing diverse and often difficult workplace experiences. Because these methods open up debate, if used well they can support the inherently political processes of consciousness raising and collective planning, which serve to identify and mobilise collective interests - the basis of putting solidarity into action.

This approach offers us a methodology that has important parallels with the psychoanalytic project, as well as the capacity to build relationality at work.[29] It can be understood as psychosocial - looking at both internal and external realities, and requiring the raising of consciousness, collectivisation and praxis (i.e. understanding reality and taking action to transform it). Its methods aim to promote a dialogue between participants - looking at their experiences of the real world, reflecting on them and making material changes, particularly in relation to wages and working conditions. For a sample 'Survival Surgery' for carrying out a meeting or event using these methods, see the online version of this article at: https://www.lwbooks.co.uk/soundings/70/cotton-annex.

In order for this model to work it has to transform 'individual dissatisfaction into collective grievance';[29] whatever organisations or networks or groups we are part of, they have to create a collective sense of injustice, including a sense of who is responsible for the situation, and sufficient organisation to shape collective demands and action. In the current mental health context, the political work of any collective project has to be built not as an ideological project but rather as a developmental one. The primary value of organising collective structures is that they are able to create spaces for dialogue between diverse interests and provide a safe environment out of which new political ideas can grow. It is on this basis that the existing networks and organisations for mental health workers will ultimately be judged.

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Notes

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