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Mental health workforce and survivor alliances: a personal story of possibilities, perils and pratfalls

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This chapter draws on an anecdote from my past to explore the potential for creating and sustaining solidarity between social movement activists concerned with mental health and mental health services. My story connects with some of the tensions and turbulence of relations that can occur in the context of seeking political alliances between elements of the mental health care workforce and critically disposed service users and survivors. In terms of my own interest and involvement in such matters over the years, the central tale is certainly not my finest hour as an activist; far from it. I refer to it here in the spirit of learning from past mistakes. Perhaps these are the sorts of lessons that movement allies ought still to be interested in, as the important alliances at stake remain underdeveloped and fragile. The road to deeper and stronger solidarity is packed with positive, transformative possibilities but also fraught with perils for respective allies and maybe a few pratfalls along the way.

I begin with a number of caveats. First, I am concerned with constructive, democratic solutions and deliberative persuasion, not with the imposition of any ready-made blueprint for action, although it is action and activism with which I am most interested. I recognise the legitimacy and power of counter-arguments to the case I wish to make, including the right to dismiss or not to engage with it, in part or whole. Second, I hope the audience for these ideas includes both potential parties to the alliances I seek: that is, members of the workforce and survivors alike. The potential for discord that I speak of is, however, a hazard for this modest writing contribution; it might just as easily upset rather than appeal to different people. So, I wish to state my intention is not to add to existing upset and discontent, although I do aim to be provocative.

My personal view is that the mental health workforce, and my nursing discipline within it, should be more politically informed, active and appreciative of the criticisms furnished by an active service user and survivor movement (McKeown, 2018, 2016a; McKeown, Wright & Gadsby 2018; McKeown,

Wright & Mercer, 2017; McKeown & White, 2015). A big part of my concern is the assertion that the labour movement does not 'get' mental health as a political issue, beyond having an interest in defending services as we currently have them, such as demanding parity of funding with general healthcare. This is not a new argument; it was first brought to my attention by Peter Sedgwick in his book *Psycho Politics* (1982), published not long after the anecdotal events described here, although I didn't read it until a few years later. This was a text written for a time that presaged the period we are living through now, where right-wing assaults on the NHS and the wider welfare state precipitated some bold resistance on the part of the left and communities. This was exemplified in Liverpool where I lived and worked (and still do) by the left-populist politics of the Militant Tendency in local government. This radical grouping within the Labour Party increased their share of the vote in three successive elections and mobilised mass demonstrations on the streets of the city centre to protest against central government budget cuts and, towards the end, the disbarring of the councillors. The decade began with riots in Toxteth and Brixton and also witnessed the failed election campaign of Michael Foot, the courageous but similarly unsuccessful 1984–85 miners' strike and other major industrial disputes such as Grunwick's and Wapping, and closed with the Hillsborough football stadium tragedy.

In or out of Liverpool, scousers were variously involved in all of these events and, through my involvement in the community and trade unions, so was I. My working career started as a nursing assistant on mental health wards in Fazakerley Hospital; I then did my general nurse training at the nearby Walton Hospital, before returning to complete mental health nurse training at Fazakerley (now renamed Aintree University Hospital). I joined the union¹ on my first day and, soon after attending a branch meeting, became a steward. We campaigned for Foot and supported the 1981 March for Jobs that set off from Liverpool Pier Head. We raised funds for the miners and hosted meetings at which they spoke in our workplaces and our communities. We supported the establishment of community, trade union and unemployed centres, which were sustained by local government grants, union funds and individual member's donations to the One Fund for All. We turned out for the budget demonstrations and eventually campaigned and raised funds for the disbarred councillors.

We shared in the pain of the Hillsborough families and survivors and, indeed, witnessed the physical and emotional consequences of that trauma in our daily work. A close colleague of mine who worked as a counsellor with Hillsborough survivors, including the bereaved families, succumbed to a mental health crisis of his own, eventually having to stop work in the NHS altogether. The extent to

which the NHS and its unions were central to the unfolding politics and events was reflected in the fact that I was due to speak for my union on the platform of the local May Day Rally in 1989 which was postponed as a mark of respect after the events at Hillsborough.

If this was just a simple tale of combative workers and unions struggling for their economic and political rights, so far so good. At the time, we in the labour movement felt we were correct in our analysis of the political economy and were confident that our prescriptions for socialism and democracy would win out in the end. To a certain extent, our arguments have been vindicated, especially in particular terms, but the durability of what we called Thatcherism then and now call neoliberalism is somewhat depressing. The current popularity of so-called Corbynism appears to further vindicate a consistent attachment to labour values over all this time and offer a new gleam of optimism.

So, what is the problem?

There is, actually, a big problem, which I want to lead into with a reflection on some events from the earliest part of my working life. In the early and late 1980s, NHS staff and nurses were sporadically in dispute about pay and service cuts. One nursing dispute about job evaluation and grading resulted in nurses eventually winning one of the biggest (on average) pay rises in their history. Earlier disputes included an ambulance workers' strike and other intermittent industrial action, including short strikes with picketing of hospital entrances, including at Fazakerley and Walton, which were the hospitals covered by my union branch. Towards the end of the 1980s and into the next decade there was a concerted, but ultimately unsuccessful, community-based union campaign to save Walton Hospital from closure. For most of these disputes, the unions worked hard to ensure the public and local communities were behind the health workers, and this was usually a fairly straightforward state of affairs, with solidarity readily offered and relied upon.

One 'constituency' that was seemingly under-represented within these solidarity networks was mental health service users, or survivors, especially organised groups; this despite there being a number of such groups across Merseyside at the time. That said, one day, when I was in attendance on a picket of the Fazakerley Hospital entrance, I noticed that also present was a man who was currently a detained patient on the ward where I was working in my first job as a nursing assistant. For the purposes of this story, I will call him Bill. Through conversing as fellow pickets, I got to know Bill in a way I perhaps never would have done in a nurse-patient relationship within the limitations

of the ward environment. As a fellow activist, Bill became known to me as a completely different person to Bill the patient.

Bill was in his late 50s, not that much older than I am now. At the time, I was in my early 20s. On the ward, Bill tended to keep himself to himself and didn't talk much with the care team or other patients. Reciprocally, the staff didn't appear to make much effort to engage Bill in conversation either, and he was seen in the system mainly as having needs for self-care, with a vulnerability to self-neglect. He had spent previous periods of his life in the local asylum (as had a few of the staff), his appearance was fairly unkempt and in staff handovers he was sometimes referred to in the pejorative clinical-colloquial as a 'burnt-out schizophrenic'. With hindsight, this paints the care team in a bad light, but my recollection was actually of a well-staffed unit, with some incredibly decent and humane staff working in a fairly impoverished environment. Use of restrictive practices such as physical restraint was low and the wards were largely peaceful environments.

Despite the undoubted qualities of the team, the service was overwhelmingly 'medical model' and the frontline treatment was medication, whether the service users wanted it or not. As such, a substantial amount of nursing staff time was devoted to attempts to persuade compliance, rather than exploring people's lives or interests (although it wouldn't be fair to say this didn't ever happen). So, Bill's interior world and his political beliefs were largely unknown to the care team, and he was seen as something of a difficult patient or, in the language of the time, a 'social problem'.

On the picket line, it took a while to strike up a dialogue but we, as it turned out, were both intrigued by each other's presence and curiosity provided a spark for some very interesting chats. Bill was haughtily dismissive of my claims to be a 'socialist' and quizzed me to elaborate and back this up with deeper reasoning. My enquiries of him to explain his antipathy to socialism precipitated the revelation that he believed anarchism to be the superior philosophy, and therefore felt our conduct of the labour dispute was wrong-headed and doomed to failure. After much conversing and Bill's entreaties that I learn more (including bringing along and lending me a well-thumbed book of collected anarchist writings), we achieved something of a rapport. That said, when we continued our discussions in the ward setting, it was never quite the same. Either Bill was determined to maintain his distance within the ward setting or the requirements of my job role demanded that I focus on clinical/administrative matters.

To be honest, I think to some extent I saw our emerging relationship as an opening to develop other conversations about welfare and care provision, as much as valuing them in their own right.

Unsurprisingly, Bill was having none of this and consistently refused to engage in talk about care and treatment issues, housing or benefits; often argumentatively. With hindsight and (I hope) greater maturity, I can see that these were entirely legitimate responses, especially from an avowed anarchist. But at the time I was confused by it and tended to regard Bill's responses towards me as inconsistent and possibly due to changes in mood.

Whatever the reasons, I never fully chased up the possibility of developing an ongoing activist relationship between Bill, me and my comrades in the local union branch. Looking back, this omission fascinates me as I think I would certainly act differently now. I am not really sure how to explain this, but I do think, on reflection, that my failure to act in this regard was indicative of broader problems in the relationship between the labour movement and survivor activism, which persist into the present day. Prime among such considerations is the aforementioned argument that the left does not have a sufficiently well-developed understanding of what a politics of mental health might look like. But also, at the time, I may have been wary of inviting Bill to a union meeting because I wasn't sure of the reception he might receive from fellow union activists, and, in turn, was concerned that there might be negative reactions towards me. Alongside this was a personal discomfort at the time with union structures and processes, hierarchies and meeting protocols, which allowed the easy get out 'Why on earth would anyone want to be at a union meeting who didn't need to be there?' Indeed, I am pretty sure that Bill would have refused any such invitation. I am conscious now that, either way, this smacks of paternalism and, if I'm honest, failures of insight, courage and solidarity on my part. I'm also conscious of a failure to think outside of the available structures and forums for a way to take forward any attempt at connecting the union with survivor activism.

My lack of confidence in my own union as a supportive place where any seeming outsider might care to be present is worth dwelling on briefly. In my experience, union activists spend quite limited amounts of time talking to each other, let alone to outsiders, about politics and political analyses of workplace issues. This is true of general political matters, and even more the case with regard to mental health politics. The fact that mental health is not discussed as a politicised issue is fairly unsurprising, as there is a deplorable lack of such interest across the board. The more general point, however, might surprise people who do not spend time in union circles but is explicable in terms of the overwhelming demands placed on grassroots activists' time responding to employer defined or initiated issues, such as discipline, grievance and bargaining over local policies and disputes.

Union forums for debate are mostly attended by the most committed of activists – effectively, a substantial minority of the total membership – and there is little time to do justice to debating tricky issues. Arguably, the debate regarding a politics of mental health is one such issue, and working out the nuances of what this could look like would need a broadening of discussions to include other participants, beyond union activists and members. New union membership renewal and organising initiatives (Gall, 2009; Hyman, 2007; Jarley, 2005; Simms, Holgate & Heery, 2013) hold some promise for opening up the relationships and communication necessary to forge the sort of dialogue and alliances that could drive such an agenda forward.

Building reciprocal solidarity in the mental health context

Most of the practised organising approaches in the UK are arguably inward-looking and emphasise internal union connections, strengthening relationships between members, between members and activists, and between members, activists and officers. Other models attempt to extend union solidarity into local communities and forge connections with other progressive groups. This is sometimes referred to as reciprocal community organising, or social movement organising, and can be seen in notable campaigns such as *Citizens* groups agitating for living wages (Wills & Simms, 2006). These approaches hark back to an era when unions and workplaces were much more attached to specific locations and communities. Also, when the union is more strongly linked to community, then matters of legitimacy are less concerning; everybody sees the value of unions, whether a member or not. A major benefit for communities of such alliance building is that unions are relatively resource rich and can mobilise these resources into community campaigns. The biggest benefit for unions is that widespread community support for union interests legitimates union action, and this is ever more important in the public sector, where the employer is effectively the government, so there is always a political edge to disputes.

An influential approach to organising was developed over decades of practice by the mainly female technical workforce at Harvard University (Hoerr, 1997; Hurd, 1993). These workers built a union from scratch by focusing primarily on kindness and friendships, so providing the basis for what has come to be known as relational organising models. Such an approach to organising was put into practice in my union branch (Saundry & McKeown, 2013). In essence, it starts with building relationships rather than talking about workplace issues or potential union responses. By the time conversations turn to workplace grievances or demands, the connections between supportive workmates has been built and can be drawn on in more typical union activity. Interestingly, the Harvard workers, inspired by feminist ideals, retained their commitment to kindness in their dealings

with the employer (Leery & Alonso, 1997). This does not mean they surrender their confidence, power or assertiveness; instead, they foreground their values by preferring calm, deliberative dialogue to angry posturing or argument. In their early negotiations with the university management, the Harvard workers secured democratic systems for ensuring the employee voice was heard from the grassroots up.

An important implication for the healthcare workforce of all this organising activity is the potential for alliances with critical service-user and survivor groups. Indeed, one of the first community union organising campaigns that the Harvard workers turned to once they had secured their rights within the university was in the nearby hospital. Their slogan was 'Pro patient, pro union'. Such developments are at the heart of more recent public-sector union organising activities that I have been involved in through my own union, Unison. The other main UK public-sector union, Unite, has developed a network of community branches in a similar spirit. Trade unionists, however, cannot always assume that there will be public support for union actions in the workplace or the community. Community–union solidarity is hard won and has to be worked at.

With colleagues, I have written at length about the value and the potential problems of organising in the mental health context (McKeown, Cresswell & Spandler, 2014; McKeown, 2016b). My union has some very progressive policy on alliances with service user groups and there are many people in the union who really appreciate the intricacies of this and the sophistication needed to transcend tensions between the workforce, service users, refusers and survivors in this tricky political territory (Unison, 2011). A fully formed progressive politics of mental health has yet to be realised and variable understandings of each other's perspectives has resulted in problems in even successful conjoint campaigns. Arguably, what might begin as a staff-related struggle makes more sense and gains legitimacy when it becomes a fight that views staff and service user problems as wrapped together. Recognition of this demands we seek to form alliances grounded in mutual recognition and respect.

Trade unionists who are mental health workers need to address issues of power imbalances within services, not reinvent them in alliances; we need to be open to all allies, critics as well as appreciative groups, and we need to remember to challenge negative media portrayals of service user allies, even when this plays into wider community support for workers. On the latter point, a 2007 union strike in Manchester gained traction in the public eye when the media recycled narratives of the workers being the last line of defence against dangerous individuals, or that they

ministered to disempowered, socially incompetent people in the community. Clearly neither stereotype was true to the active and able survivor supporters of the industrial action (McKeown, 2009). Similar tensions have to be worked out between more broadly framed disability social movement groups and mental health activists (McKeown & Spandler, 2015).

Back to the future?

Reflecting on my encounters with Bill, I believe that if those events in my early career as a nurse and union activist had occurred more recently, against a backdrop of a union movement more committed to progressive models of organising, the outcome might have been different. One possibility is that Bill and I might have developed a deeper, more comradely relationship and this solidarity might have led us to interesting dialogue within and outwith the union branch in which we worked out implications for a new politics of mental health. In doing so, we could have drawn on a mutual interest in the anarchist-inspired notion of prefiguration – how we might shape the world we would like to see in the course of striving to achieve it. We would both have been able to engage with Sedgwick's book, which, among other things, vindicates Bill's criticisms of the socialist left and offers a path to a new politics of mental health that makes the most of both anarchist and socialist thinking. Reciprocal community organising would have enabled connections with service user and survivor groups in the community and joint activism within each other's campaigns; it would have promoted dialogue between workers and progressive mental health activists. Ultimately, a new politics forged in such a way would envision alternative forms of care provision that are better for both service users and staff and would effectively link socio-political understandings of mental health and society as a whole.

While exercising our imagination, we also need to contemplate some of the possible pitfalls. All parties may enter discussions and dialogue and joint actions in good faith, but problems may arise because of variable commitment to the process, or disagreement over ends or means. A consequence of this would be a sort of imperfect solidarity. This would be more likely if there was insufficient effort put into organising dialogue and debate, or if workers reverted in their activist alliances, even unconsciously, to prevailing workplace cultures and power imbalances. The lack of a reflective politics of mental health can be a chicken-and-egg scenario; either it derails discussions early on or differences constrain the collective capacity to formulate the necessary ideas for such a politics to emerge. Here it is worth revisiting Sedgwick, who suggests the commitment to an ethos of prefiguration is a way out of such pitfalls (Moth & McKeown, 2016; Spandler et al, 2016). This means that relationships and communication within alliances demand careful and concerted effort. They

need to be worked at and nurtured, and not abandoned at the first sight of turbulence (Church, 1995, 1996). Careful dialogue is deliberative, is given sufficient time and ideally reflects care for each other, even when differences are asserted (Barnes, 2012).

One of the many lessons for me from my encounters with Bill, confirmed across subsequent years of attempting to do a better job of forging alliances, is that the place in which dialogue takes place is important. So too are the efforts made to ensure the conditions for constructive dialogue are established. Shifting the setting in which conversations take place from clinical to activist environments makes for better, more respectful relationships, allowing richer, more fruitful dialogue, including the discussion of the political and the personal. Thus, I have been fortunate to play the role of ally¹ to a number of self-organised groups concerned with mental health politics. One of these, a radical group in Liverpool called ReVision, has worked alongside local trade union activists and other critical groupings such as the Social Work Action Network (SWAN). ReVision also received a grant from The Edge Fund² to bring together trade union and service user activists in creative writing workshops, with the ultimate aim of forming personal connections to sustain solidarity.

ReVision have developed their own manifesto and contributed to the drafting of SWAN's Charter for Mental Health³ (Kinney & Wilson, 2016). With other local service user and survivor activists, ReVision also played a key role alongside trade unions in the SOS (Save Our Sanity) campaign, which successfully defended cuts to day services and also ushered in fresh dialogue about how best to deliver such services in the future. This campaign also involved connections and solidarity with similar campaigns elsewhere in the country, with activists from Cambridge and Salford attending meetings and protests in Liverpool (Moth, Greener & Stoll, 2015). These initiatives and struggles, although imperfect in many ways, demonstrate the potential of solidarity alliances and the start of work to develop ideas that could form more progressive demands on mental health services and wider society. Some of the imperfections in these and other efforts may be a result of plunging into struggle without having spent sufficient time and energy in forging the alliance beforehand. Needs must, especially in neoliberal times, but the legacy of decades of survivor activism also point to some strategies for laying more solid foundations for political alliances.

Truth and reconciliation

¹ See Russo, Beresford and O'Hagan (2018) for critical discussion on the notion of allies in this context.

One of the impediments to alliances between the mental health care workforce and users and survivors of the system is the history of and on-going harm inflicted in and by that system. Arguably, a powerful feature of these harms, extending hurt of different sorts to both service users and staff caught up in the system, is the epistemic nature of the injustices therein (Fricker, 2007; Russo & Beresford, 2015). With Helen Spandler, I have revisited a previous call from the survivor movement for a form of truth and reconciliation process within mental health services (Spandler & McKeown, 2017). We see a grassroots truth and reconciliation approach as a potential stepping stone to the sort of dialogue necessary to establish more genuine and powerful solidarity among workers, service users and survivors. Along the way we hope to begin the process of healing some of the harms implicit in the mental health system as we know it. This in and of itself would appear sufficient grounds for attempting such an initiative.

We have discussed this idea in meetings of critical scholars and mental health activists, such as conferences convened by Mad Studies and the Critical Voices Network Ireland, with both positive and critical reaction (McKeown, 2016c; Russo, 2017). With Jan Wallcraft, who initiated an earlier petition for truth and reconciliation in psychiatry, we organised a fringe meeting to discuss this with Unison activists at their health delegate conference in Liverpool in 2017. This meeting exceeded our expectations for how well delegates would receive the ideas we presented, and we will be following this up in future dialogue with the union.

Conclusion: trust the tale

DH Lawrence once famously declaimed: 'Never trust the artist, trust the tale.' In the mental health field, matters of trust and tales are important in many ways, and connect with the ideas developed in this chapter. Narrow, biological psychiatry, legitimated and administered via a coercive legal framework, delivers alienating and violent experiences and outcomes, as we see in numerous testimonies, not least in the pages of this book. The very narratives that sustain psychiatric hegemony are a big part of the problem and their existence and effects constrain and deform the stories that many service users and staff are able to tell about themselves.

Union renewal campaigns are a potential opening for thinking about alliances with mental health service users and survivors and doing something constructive to build them. In the different context of attempting to organise nurses in a union in a Californian hospital managed by Catholic nuns, it is interesting to see how an element of the organising campaign illustrates a connection to epistemic concerns (Reich, 2012). Traditional organising methods were not gaining any traction, in a place

where the Catholic workforce and surrounding community respected the nuns and their vocational ideals and remembered their solidarity with striking farm workers in a previous labour dispute, when some nuns were jailed for supporting the strikers. The current workforce, however, were left in a bind: respect for the nuns was not helping them address important differences about pay and other aspects of their employment. The nuns' support for the unions did not extend to those within their own hospital, where the workforce was expected to be vocational, meek and selfless. The success of the organising campaign turned on the unions foregrounding moral issues about what is right and fair, with the implication that the nuns were on the wrong side of this debate.

To me, this turning of epistemic tables is also open to activists in the mental health context. The stories we tell or buy into effectively legitimise psychiatry, or aspects of it. A new politics of mental health is an alternative story (a different way of knowing, a morality tale, or episteme) and can be constructed through attention to a range of stories told from different perspectives. A prefigurative process of dialogue and testimony is one way of achieving this and, in turn, laying the foundations for future alliances. Thus, truth and reconciliation may be the way to inject more trust in hearing and respecting each other's tales. From there, we ought to be better placed to engage in care-full interaction that might help us arrive at an insightful and workable, progressive politics of mental health and sustain more authentic solidarity to take into important struggles. This feels like a goal worth striving for.

Bill's tale is now part of my own, but its influence at the time was held back by my own inability to fully trust it and appreciate its value. The beauty of our humanity is that we are able to learn from mistakes and do better next time. I met Bill in the course of a struggle I defined at the time largely from a worker perspective. I have come to appreciate over the years something that activists down the ages have always known: that any dispute worth winning has to extend its appeal and benefits to a much wider constituency. If we define our demands narrowly, we only ever win narrow victories. My lesson from a combination of insights from Bill and Peter Sedgwick, and countless others, is that the transformation of psychiatry and society can be one and the same thing.

To contemplate such change is to engage in an ongoing struggle, a struggle that arguably can't be won, or the victory won't be worth having, unless we take it on in an authentic alliance. Nye Bevan's (1952: 170) views are salutary, we need to both enjoy the struggle and recognise 'that progress is not the elimination of struggle but rather a change in its terms'.

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Footnotes:

1. COHSE (Confederation of Health Service Employees, later subsumed into Unison)
2. The Edge Fund for radical change <https://edgefund.org.uk/>
3. SWAN Charter for Mental Health
<http://socialworkfuture.org/attachments/article/172/SWAN%20Mental%20Health%20Charter.pdf>