Working With(in) Austerity

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It's Sunday and, as usual, we're sat down to a roast dinner. Around the table are my three sisters, my brother, my parents. Mum holds up a plate of Yorkshire puddings and offers it to me. Do I want one? I'm not sure…there are only four…we can't all have one. So do I take the food that has been offered, and feel guilty that others miss out. Or do I refuse (though I am still hungry), deciding that others' needs outweigh my own. At a family meal, individual needs and collective needs are bound.

I often think about these times with family during my work on an eating disorders inpatient ward, where staff and patients struggle with the offering and refusing of food (and other 'nourishment'). If we think about treatment as a 'communal meal' we might *all* worry, "What if there isn't enough to go around?". Although much discourse in Western media is about excess – waste, obesity, celebrity, overspending – problems of 'not enough' have by no means disappeared. And although common views of eating disorders might focus on the *refusal* to eat, there is another tangled problem around trying to take one's share of what is offered.

The National Health Service as a whole plays out these opposing problems – vast spending yet significant unmet need. Anyone working in the NHS is familiar with budget cuts, alongside target increases, alongside team 'downsizing', alongside salary downgrading. It does not feel like you are awash in billions of pounds when you watch your therapy waiting list creep past the year mark. These problems have worsened considerably since widespread cuts to public services began to be implemented as part of the policy of 'Austerity' championed by the last coalition government.

Trimmed spending causes problems in any department, but there is a particular destructive resonance within eating disorders services. In general, our patients feel guilty about taking *anything* for themselves: be it food, comfort, autonomy or

relaxation. Placed in an environment like the NHS ward where I work, they see staff not replaced, buildings not maintained, therapist numbers diluted. Such conditions are like golden tickets to the parts of their minds that tend to 'do without', refuse, not ask and 'not need'. How can we provide a good service within a climate of austerity that so convincingly mimics the pathology of their illness?

In trying to answer this question, I recall my own past. I grew up in a pleasant suburb in a commuter town. My mum was a housewife; my dad had a career of good jobs in financial management. Hardly impoverished. However, for a significant portion of my childhood, money was very tight – in the late 1980s interest rates went sky-high just as my parents committed to a larger mortgage, had a (4th) baby, and my dad was made redundant. I'm the eldest of five siblings and we were keenly aware of each others' needs. It's the period of cooking my mum wryly calls, "1001 things to do with mince". None of us was starving, but we knew there were things our family could not afford – Kellogg's anything; going to restaurants; 'interesting' fruit. So we learned not to ask for certain things; we knew they could not be given. When taking anything, we took each other into account.

On the ward, austerity affects staff by confusing the picture of what is offered in the treatment – is this sense of 'not doing enough' a projection from the patients' illness, or do I actually not have what I need to do my job properly? Most important, it affects staff who are subject to the same tendencies as patients to ignore their own needs and to work to impossible standards, at the cost of their own mental and physical well-being. Austerity has been shown to be hugely detrimental to mental health (McGrath, Griffin & Mundy, 2015). It has been described as leading to five types of harm: humiliation and shame; fear and distrust; instability and insecurity; isolation and loneliness; being trapped and powerless (id.). These feelings – in staff or patients – are not conducive to offering or accepting safe, excellent care.

Interestingly, when I think about my time growing up with stretched resources, I don't recall a sense of deprivation (though I did long for 'real' Coke, not Panda Cola!). This is partly because my parents made sensible choices and we did have all the essentials; but also because their approach was one of *frugality* not austerity. In its common use, 'frugal' has probably got as bad a press as 'austere'; however, the root of its meaning

is aligned with 'fruitfulness' – making the most of what you have. Austerity's roots are in the meaning 'severe'. Quite a contrast in feeling-tone. Not being able to afford restaurant food or branded goods didn't mean we did without; we often made things ourselves. In fact, one of my happiest memories is of picking rose leaves with my mum and painting them with chocolate to use as cake decorations for a friend's birthday.

The other crucial value my parents instilled in us was that as siblings we were there to look after each other, not to compete with each other. This emphasis on *collaboration* rather than competition meant that sharing things equally felt right and natural, rather than a missed opportunity. I'm not suggesting we were five angels – there was plenty of squabbling round the Sunday dining table for the tallest Yorkshire puddings – but the general approach was cooperative. It felt kind.

In contrast to an austere outlook, a frugal approach *can* uphold the values of a psychologically healthy community (be that a family, a ward, or a society), provided it is characterized by agency, security, connection, meaning and trust (McGrath et al., 2015). There has been some superb work recently in thinking about the values of the NHS and how these have been altered by the increasingly commercial approach to how it is run (Ballatt & Campling, 2011). Caring (professionally) has been damaged by the competitive anxiety associated with a business model. The fundamental distortion is the idea that healthcare is a zero sum game: for someone to 'succeed' someone else must 'fail'; therefore by being kind to others I damage my own chances.

Austerity politics and its impact in social and health care services is rife with language of conflict, blame, and belittlement, setting one person against another. This is a poor approach to long-term relationships between people. It is a poor model for the NHS, where the successes and failures of staff and patients, managers and employees, professionals and the public are inextricably bound. The distortion is linked with a misunderstanding of the concept of kindness, which has been downgraded across recent history from a primary virtue worth considerable effort and attention, to a marginalized (and 'femine-ized') romantic frivolity. The word 'kind'

derives from the same root as ‘kin’ – those to whom we are close. Being kind to those in our communities is not simply being ‘nice’. It leads to a better deal for us all.

On our ward, we are paying careful attention to how fruitful co-production between patients and staff (and within those groups) can improve the treatment experience for all members of the community. Generally this work does not require substantial financial investment, but is about improving the quality of day-to-day interactions and the environment. One good example comes from the thinking around the ward’s ‘family meal’; that is, developing a framework for approaching eating together in the communal dining room. Recently, a document revising and re-describing the dining room boundaries was drafted iteratively within the staff team and with patients, resulting in the *Principles for Therapeutic Eating*. These standards were simpler for staff to remember and implement, better matched to the patient group on the ward, and more acceptable to patients as ‘principles’ rather than ‘boundaries’.

This is a *frugal* solution: in a climate of austerity, it is hard to justify allocating more staff to sit in the dining room during meals, but patients tell us it is the quality of the support that matters most, not just ‘bodies’ policing the eating. Good principles foster good co-operative relationships and avoid a competitive situation in which the needs of either staff or patient must triumph. This kind of ‘co-production’ must not become a fig-leaf for frank underinvestment and we have taken a (constructively) critical approach to the whole notion of ‘co-production’ (Adlam et al., 2016).

Thinking back to the situation in my family, our experience of sharing, of holding each other's needs in mind and being creative, would not have been sufficient were we in actual poverty. There is much still to do towards improving the kindness in our treatments, but my hope is that by adopting a frugal, creative, collaborative approach to treatment as a whole we can make the most of what we have, thereby creating the clearest case to argue for investment where it is still needed.

And in case you were wondering what I did about the Yorkshire pudding? Cut it in half and shared it, naturally!

References

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