



GILLIAN PROCTOR REFLECTS ON THE ACCURACY OF HER 2002 PREDICTIONS ABOUT THE FUTURE OF THE HEALTH SERVICE



In 2002, I wrote an article in this journal¹ as though it was 2015 and I was tracing the (at that point) fictional history of the NHS from 1985 to 2015. This was based on my experiences in 2002 with the healthcare system in the US; the discourses that were current in the UK at the time seemed to prefigure a move to an insurance-based healthcare system provided by the private sector. In this article, I reflect on the extent to which my predictions from 2002 were accurate and predict again the possible changes to come.

In 2002, I described the ‘efficiency’ and ‘accountability’ discourses, which were becoming increasingly prominent at the time. The ‘efficiency’ discourse was used to argue that better management of existing resources would improve healthcare, rather than increasing resources. This justified the split between ‘purchasers’ and ‘providers’, which led to the ‘commissioners’ and ‘providers’ division of today. The ‘accountability’ discourse was used to scare the public about ‘rogue practitioners’ doing their own thing and justified the transfer of power from healthcare professionals to managers, with professionals needing to prove that their practice was ‘evidence based’. This approach supported an industry of regulating bodies, such as NICE, in deciding what would count as evidence, and in increasing the power of approaches within mental health that fitted nicely within a technological, scientific model (such as CBT), moving mental healthcare further away from the idea of relationships, and professionals further away from the idea that who and how we are as people matters. These discourses perpetuate the myth of standardising mental healthcare, as though any human relating can be done in a uniform way.

As part of this approach, the notion of performance-related pay was already being mooted in 2002, which I predicted would be introduced across the board, with individuals being judged by their ‘efficiency’ and adherence to ‘evidence-based practice’. These discourses have since been described by Rizq²⁻⁴ as characterising

the New Public Management (NPM) policy changes in public sector services (health, education and social services) since the 1980s. She explains that these organisational structures are ‘increasingly characterised by managerialism, surveillance and bureaucracy and privilege efficiency, performance and transparency, over professional accountability and collegiality’.³

I also described the effect of the purchaser-provider split, which was to establish the split between public and private healthcare, and predicted that employers paying for private healthcare for their employees would become more common. As a result, funding for public healthcare would be reduced and the necessity for private healthcare increased, with public healthcare remaining just for emergency healthcare procedures. I predicted that purchasers would become insurance companies, which would be unregulated and they could decide themselves which treatments would be deemed ‘essential’ and ‘effective’, agreeing to evidence-based interventions for particular diagnoses. This would lead to service provision being completely based around diagnosis and limiting services to those that were financially viable or financially subsidised by interested parties, such as pharmaceutical companies, who would also have stakes in the insurance companies, thus ensuring profits all round, rather than any focus on patient care. In this insurance-based system, patients with ‘pre-existing conditions’ would be refused treatment, which would lead to many people refraining from visiting medical professionals in case a diagnosis was made which would then become a ‘pre-existing condition’ and limit future care.

So how far are we now from this financially based American system? Thankfully, as yet, the healthcare system in the UK has managed to resist completely following this profit-based trajectory, although I would argue that, in many ways, we are not far away, while still being able to maintain a discourse of an NHS which is ‘free at the point of access for all’. Clearly, it is politically important to maintain the illusion of protecting the key

philosophy of free healthcare for all. In the lead up to this year's general election, the NHS became the issue of greatest salience for the British electorate for the first time since 2006,⁵ being mentioned by 45 per cent of people as among the most important issues facing Britain. However, the issue was much more likely to be seen as important by those aged over 55 (51%) compared with those aged between 18 and 24 (24%). Clearly, the future of the NHS is an issue that no political party can afford to ignore currently, with all parties offering reassurances about its future and increased resources.

NPM policies have continued to strengthen since 2002. The discourses of 'efficiency' and 'evidence-based practice' have proliferated, with cuts to NHS and all public sector funding having been renamed 'efficiency savings'. Purchasers have become Clinical Commissioning Groups (CCGs) most recently, and providers can be from the NHS, voluntary sector, social enterprises or private sector. Services are tendered for, with bids from each competing provider, with the least costly often being judged the most 'efficient' and best value. In an attempt to submit the lowest cost bids, service provision is limited to small numbers of sessions and the practitioners who provide the service are either the cheapest possible counsellors (ideally working voluntarily and often highly experienced and qualified), or the most compliant and usually the least qualified and experienced 'low-intensity' workers.

“There is no space for emotions, attachments or feelings in counsellors for the clients they have relationships with”

THE DOMINATION OF IAPT

Mental health services are now dominated by IAPT, which focuses exclusively on 'evidence-based' and short-term interventions for clients with particular diagnoses (mainly anxiety disorders and depression). The vast majority of workers in IAPT services offer CBT, often by minimally trained psychological wellbeing practitioners (PWP) offering 'low-intensity' interventions for a small number of sessions (usually six). More recently, IAPT committed to extending the 'choice' for patients to other modalities of therapy which are mandated by the NICE guidelines for depression,

which include counselling for depression (CfD), interpersonal psychotherapy (IPT), dynamic interpersonal therapy (DIT) and couple therapy for depression (CofD), each of which have had to go through the process of providing enough evidence through randomised controlled trials (RCTs) to prove their effectiveness with clients diagnosed with depression. Yet evidence from a survey by UKCP and BPC⁶ suggests that, overall in mental health services, there has been a reduction in choice for patients, with a decrease in the length, intensity and type of psychotherapy provided, the number of clients accessing longer-term psychotherapy and an increase in waiting times. At the same time, the clinical experience and qualifications of those providing the psychotherapy have decreased.

Of course, in reality most clients entering IAPT services could not be diagnosed with simple depression or anxiety, with a mixture being much more common,⁷ but the inadequacies of applying the medical model and RCT research conditions to a clinical population are ignored. Some consequences of these limited therapy options are to create a new industry in training already trained and experienced clinicians in an evidence-based therapy and further demoralising and devaluing the existing workforce.

The idea of diagnoses being used to decide which evidence-based interventions clinicians can offer has indeed been introduced across mental health services, with mental health diagnoses being renamed as 'clusters', focusing mainly on severity and level of need as opposed to type of difficulties. This is a handy idea, meaning all mental health professionals are able to 'cluster', thus not limiting the process of diagnosis to psychiatrists. Clusters now form the basis of the national tariff payment system whereby provider services are allocated a certain amount of money to treat each patient (tariff), depending on their cluster. Using a Mental Health Clustering Tool (MHCT) to evaluate outcomes has now been recommended in England.⁸ Fugard⁹ discusses one of the problems here of recommending an unreliable measure with very poor internal consistency.

Rizq⁴ points out how these mental health policies take for granted the uncritical acceptance of diagnoses on which the whole system is based, and yet the system is still haunted by the previous historical view of madness as signalling unreason and being scary – the dehumanisation of madness. This fear of the 'other' leads to constant anxieties about the shared human experiences of vulnerability, fragmentation and death among those who work in the system and in the organisations themselves. At the same time, the policy and language shift from 'mental illness/health' to 'wellbeing' emphasises the needs to be ubiquitous and human and, at the same time, disavow the messiness (unpredictability and 'unmeasurability') of distress.

FOCUS ON MEASUREMENT

The emphasis on evidence and standardisation leads to an overwhelming focus on measurement in IAPT settings. Each client is required to complete the Minimum Data Set (MDS) of outcome questionnaires at each appointment, and clients are deemed to have 'reached recovery' if their scores have reduced from above to below a certain threshold. This use of outcome measures to mimic evidence-based practice is extremely suspect, with the questionnaires used having little validity (having been devised to measure the effects of medication by pharmaceutical companies, as opposed to other measures that have some validity to measure change in psychological therapy, such as CORE outcome measures¹⁰) and used because they are free. Results are reported without any explanation of contexts or differing starting populations in different areas. Services have the constant pressure of being able to successfully report good recovery rates, which are used to compare across services and these pressures are often transferred to psychological therapists. This pressure to produce good figures cannot but affect the work of the counsellor in therapy, with the consequence of a service focus on 'symptoms' that are measured by the MDS at the expense of the factors that are important to the client in distress. The pressure on clinicians to see large numbers of clients leaves little room for other clinical activities such as supervision and support, or any opportunities for reflection about our work, leading to high levels of stress. Often IAPT service managers are not counsellors or psychotherapists, have little understanding of the importance of relationships, and focus exclusively on the political targets of waiting times and recovery rates.

Wainwright¹¹ critiques the implementation of systems for quality improvement on their lack of evidence base and suggests that organisational ethics need to be considered, with respect to how much the way an organisation functions encourages or discourages ethical thinking and behaviour. He suggests that the push towards standardisation in healthcare is not only impractical due to complexity but can also lead to the demoralisation of the workforce. Similarly, he critiques the target-driven culture of the NHS, not denying that usually targets are achieved, but that, at the same time, 'they may also have serious consequences that may be concealed', and that these consequences may work against the purpose of the original target. It is not difficult to apply his analysis to the IAPT culture of attempting to standardise mental healthcare, setting targets for recovery and, at the same time, discouraging ethical behaviour in practitioners by the constant focus on numbers as opposed to people and relationships, and drastically decreasing the morale of the workforce, due to high workload, stress, and little support. At the same time, the focus on recovery rates conceals the consequences for many clients, such as those who are refused a service because they are measured as not needing one (they don't meet 'caseness'), those clients whose service finishes because their measures demonstrate they have 'recovered' but their personal

goals are far from being met, or those clients who do not have the choice of the kind of therapy they would like, as they have already dropped out of a service after one experience with a worker who didn't seem to understand their personal difficulties. Similarly obscured is the reduction in longer-term psychotherapy options for clients who need much more than the IAPT symptom-focused short-term model on offer (see UKCP/BPC, 2013⁶).

Rizq⁴ further identifies the IAPT programme as exemplifying the NPM ideals of transparency, accountability and governance, and describes how the 'virtual reality' of the activity data is part of the wider discourse of 'evidence-based practice'. She draws on the Lacanian notion of a 'fetish' to describe how these measuring practices are an 'attractive fabrication' which conceal the lack of ability of the service to respond to distress with care. Thus the fetishisation of bureaucracy disavows our anxieties about vulnerability, illness and death. Hence IAPT represents a case par excellence of 'one in which the dependency and psychological suffering of patients, as well as the anxieties and limitations of those tasked for caring for them, are simultaneously disavowed and concealed beneath overwhelming bureaucratic and governance systems'.

I would argue that it is not just our anxiety about vulnerability, illness and death which is being concealed by this insistence on measuring 'symptoms' of 'illnesses'. This preoccupation also conceals a huge amount of evidence about the causes of distress not being physiological or biological (as in a medical model), but being social and political. The evidence that is most convincing relates causes of distress to environmental factors, such as abuse, deprivation, violence, discrimination, powerlessness and unemployment (see Proctor^{12,13}). IAPT services, particularly in areas of deprivation, will be caught between service requirements and trying to respond to the real social and material needs of their clients, with the separation of experiences of anxiety and depression from these needs (as mandated by IAPT) being completely impossible. This leaves both clients and clinicians stuck between their reality and service discourses that make no sense at all; a true recipe for madness! Further, it leaves psychological therapies yet more open to the accusation of being responsible for further perpetuating the inequalities that cause the problems that they are supposed to be addressing (see Proctor¹³).

IAPT also plans to adopt a system of Payment by Results (PbR), but rather than this being based on activity or needs (as in the clustering model), it is proposed to base this on outcomes as measured by the MDS. As Fugart⁹ points out, this will exacerbate further the difficulties in the MDS being a good measure of outcome, as once a measure becomes a target, it ceases to be a good measure,¹⁴ being vulnerable to obvious manipulation by service providers and users who want to ensure the survival of their service. As Fugart⁹ summarises: 'It is difficult to see how any data gathered

that have been subject to these difficulties could tell clinicians or service providers anything helpful about their services or the wellbeing of those who use them.' Fugart⁹ points out an additional problem with publishing recovery rates on league tables, without any information on uncertainty or without any context of interpretation. The effect of this on psychological therapists working in IAPT services is that there is a continual battle with recovery measures, with constant ethical dilemmas about what to do with clients who don't recover, or with scores which don't reach above 'caseness' at the start and, therefore, can never demonstrate recovery, and a constant challenge to try to respond to individual need rather than focus on the service demands of bringing about change as quickly as possible, as demonstrated by an outcome measure.

At the same time, many IAPT services are now not provided by NHS providers, with counsellors often working on zero hours contracts, not being paid if clients do not attend, and sometimes only being paid if clients 'reach recovery', with the counsellor thus evidencing their effectiveness. This is, of course, performance-related pay with reduced terms and conditions way beyond what I had envisaged in 2002. Whereas the US insurance-based system does indeed reduce rewards and increase administrative pressures for clinicians, this NPM bureaucratic system in the UK at least equals the resultant change of emphasis from clinical to administrative skills on healthcare workers, with consequent increases in stress and decreases in morale. Both systems also equally shift the focus from collaborative relationships between experienced clinicians and unique clients to measurable and standardised outcomes of treatment.

Rizq³ suggests that the preoccupation with measuring also serves the function of trying to define the borders of its culture and keeping out the parts that she describes as 'abject' (disavowed and pushed away in disgust) following Kristeva.¹⁵ In mental health services, the experience of distress and vulnerability are abjected, to be replaced by 'wellbeing' and financial and economic productivity. However, the abject in fact can never be entirely discarded, but always remains just out of reach, in the shadows of subjectivity. Mental health services remain in the precarious position of being mandated to provide care for mental distress, yet operate within bureaucratic systems that serve to regulate, disavow and abject the very care that they are mandated to provide. She warns that psychotherapists who engage with emotions and attempt to relate with care are in danger of containing all the abject within the service and are thus at risk of burnout.²

There is a real question of how the other new approaches can fit into the IAPT system, which has a clear focus on the 'symptoms, thoughts and behaviour' of consumers who have the agency to choose the approach which suits them. The focus in CfD (the only humanistically based approach offered within IAPT – see Sanders and Hill¹⁶) on emotions does not fit the wellbeing agenda, where emotions are abjected, and threatens the defence.

The focus in CfD on the unique person rather than any diagnosis also struggles to fit with the diagnostic foundations of the service. IAPT is not set up to offer care to the vulnerable but to offer 'choices' for people who want to 'deal with' or 'address' their deficits in wellbeing, or their symptoms of mental ill-health. There is no space for emotions, attachments or feelings in counsellors for the clients they have relationships with, topics which used to be legitimate subjects in supervision for psychological therapists. Although counsellors should still have supervision from a supervisor using the approach that they work with (such as CfD), the priority for management is often now 'case management', focusing on changes in the MDS and how quickly clients can be discharged; this says it all – clients have become 'cases' to be managed, not people to be related to, worried or concerned about.

CONTINUING PRIVATISATION

In the meantime, the privatisation of the NHS continues surreptitiously. The Transatlantic Trade and Investment Partnership (TTIP) is a proposed deal between the EU and the US, which would enable US companies to become much more involved in the provision of many former public services such as education, water, rail and healthcare services, in the UK (providing health, medical and dental services). The TTIP deal includes an ISDS (investor-state dispute settlement) clause, enabling our Government to be sued by private corporations in secret courts for passing laws that threaten the profits of these companies. This deal would effectively make a reversing of the privatisation of our healthcare services financially impossible.

The role of non-NHS providers in delivering NHS-funded care in England increased markedly from 2006 to 2012, reflecting explicit policy decisions.¹⁷ In 2006, the NHS spent £5.6 billion (in 2011/12 prices) on care provided by non-NHS providers; by 2011-2012, this had increased to £8.7 billion¹⁷. Care by private providers grew more quickly than by voluntary sector or local authority providers. Paying for private healthcare insurance or treatment fell during the same period, with private providers gaining more of their income from the NHS. Currently, self-pay is the area that is growing the most in the NHS, with individuals choosing to pay privately for specific services, mainly elective operations, although it is likely this will spread to other areas, such as mental health.

*The Nuffield report*¹⁷ warns about competitive distortions between NHS and non-NHS providers, recognising the strategies used to 'be competitive' in private industry. It is certainly possible that private companies can submit a very competitive tender to provide a service and then use patients who access this service, which will inevitably make a loss, to ensure profits in other services. Within all of this, it is never clear to me how private healthcare organisations can possibly represent better value for money than organisations who do not aim to make a profit, but aim to deliver the best care possible within the financial

constraints. The only possible way for private companies to deliver better care to patients, at a lower cost than NHS providers, is by reducing the pay or terms and conditions offered to its employees.

“The pressure on clinicians to see large numbers of clients leaves little room for other clinical activities such as supervision and support”

The saturation of the discourse of evidence-based practice now means that this is a rarely contested given, with outcome measures and clustering being used without any consideration for their validity or effects on client care. It seems that the move from values-based healthcare¹⁸ to the illusion of value-free technological-based healthcare is nearly complete. Despite exposure to the inadequacies and even tricks involved in producing evidence and clear values and dynamics of power involved in what questions are asked and how they are answered in research, and the lack of applicability of experimental research to real life, the idea of the gold standard of ‘evidence’ being the RCT remains.

Rizq⁴ refers to the NPM restructuring of the NHS since the 1980s, including the introduction of quasi-markets, quality management, competitive tendering and other market-related reforms. She suggests that these neo-liberal regulatory and performance management systems are a perverse organisational solution to the difficulties of dealing with distressed patients; perverse in that these systems pretend to deal with this distress (by measuring it) and, at the same time, disavow the distress. Ultimately, the consequent ‘tick box culture’

created undermines the chances of staff really responding to distress by undermining care and human relating. *The Francis report*¹⁹ holds this culture responsible for deaths, saying ‘statistics, benchmarks and action plans are tools not ends in themselves. They should not come before patients and their experiences’.

Yet most people working in the NHS chose to do the jobs they do because of their values and their wish to help people in an ethical and meaningful way. There is a long tradition of other approaches to ethics in healthcare that offer meaningful alternatives to the quasi-legal technological approaches. Values-based ethics of care and relational ethics prioritise the importance of people and relationships, as opposed to techniques and interventions and, of course, these ideas are at the heart of counselling and therapy, where there is little disputing the evidence that the relationship matters (see Cooper²⁰). As long as we continue not to question the politics and values behind the taken-for-granted mandates of ‘evidence’ (as though such a thing was an undisputed fact, as opposed to a highly political funded justification), it will get harder and harder for those of us who like to live and work in accordance with our most cherished ethics and values to remain within the NHS.

So the current political climate mandates any changes to the NHS to maintain the illusion of a continuation of the cherished British tradition of publicly funded healthcare, thus limiting the move towards an insurance-based system. However, through the saturated discourse of ‘efficiency savings’ and ‘austerity measures’, which are barely contested, the increase of competitive tendering for all provider services is set to reduce stability and equity of service, and decimate terms and conditions for employees. The public service might still seem to be public for the patients, but the good terms and conditions, which came with the low pay attached to most public sector jobs, have already reduced substantially in the last five years and are set to continue to reduce much further across the board. At the same time, the days of autonomy, opportunities for innovative practice, valuing relationships, and being trusted as a clinician are long gone, with the discourse of ‘evidence-based practice’ successfully leaving many clinical decisions to NICE and CCG funding decisions. Consequently, morale and goodwill among the workforce has plummeted.

Startlingly, since 1997, the percentage of members of BACP who are also members of the BACP Healthcare division has fallen from nearly 12 per cent in 1997 to seven per cent in 2002 (when I previously imagined the current situation), to 2.8 per cent currently. This decrease is likely to chart the reduction of counsellors who work in healthcare settings during this era of increased regulatory and performance management systems. More and more NHS practitioners are moving away from what was an ethical choice to work for a free at the point of access service, to try and work independently, perhaps offering services privately or

becoming AQPs (Any Qualified Providers) to independently provide services for commissioners. Both these options offer much less stable forms of income than previous NHS contracts did for counsellors and psychotherapists, and leave patients vulnerable to inequities of funding decisions and constantly changing services.

LINES OF RESISTANCE?

Are there still lines of resistance for counsellors and psychotherapists in the NHS who value humanity, relationships, and want to work with distress and powerlessness, as opposed to the denial of inequalities and the messy emotional work which is mental healthcare? Is there hope where unusual IAPT managers can still focus on these values in addition to the political priorities of recovery rates? Can we resist and still survive without our values being compromised beyond a level where we can still recognise and live with ourselves? Can we work collaboratively to help each other survive in solidarity and, for the sake of our clients and the future of an NHS, where the values of human care and relationships still matter?

I remain hopeful that despite the ongoing privatisation of our cherished NHS (while maintaining the illusion of a public service), our values as counsellors and psychotherapists can have an impact on individual clients. Perhaps, in areas where there is a critical mass and support among counsellors and managers with such values, these values can influence services for the benefit of client care. But we are fighting against an extremely powerful tide of bureaucracy and free market economics, and the stakes and ongoing costs of this fight for survival of alternative perspectives are high. ■

Dr Gillian Proctor worked in the NHS as a clinical psychologist and psychological therapist for 22 years until she took redundancy in 2013. She now works as an independent clinical psychologist, psychotherapist, and clinical and research supervisor (www.gillianproctor.co.uk) and as an Associate Professor of Counselling at the University of Nottingham, delivering courses on counselling for depression (CfD). She is also an Associate Lecturer at the University of Huddersfield. Gillian welcomes responses from anyone who wants to form a network for discussion of, and support for, how to survive as a counsellor in the NHS, to Gillian.Proctor@nottingham.ac.uk.

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READER RESPONSE

The author welcomes correspondence about this article. To contact Gillian, please email hcpj.editorial@bacp.co.uk