The dynamics of social inclusion

Some thoughts towards anti-discriminatory practice

by Ian Popperwell

The extent to which mental health services as we know them have a role to play in people’s lives beyond clinical interventions, and even where those clinical boundaries might lie, as people increasingly take their rightful place in normal mainstream life, is very much up for grabs. The Social Exclusion Unit’s report “Mental health and social exclusion” (ODPM, 2004) demonstrated in grave terms the extent of the exclusion – the discrimination, isolation, absence from all major areas of life, stigma, and poverty – of people who have or have had mental health difficulties. My own conclusion from the report and all the associated gathered knowledge is that our society has to fundamentally shift in order to include people, who, through their representation of such a degree of difference, it has contrived to keep out.

The part that the mental health system itself has played in maintaining this exclusion and what it represents for that system is certainly worth some attention. Unless we can manage to address these issues, I fear that we will hardly be able to show any depth of change in the orientation of services, levels of inclusion or discrimination. I describe these issues as the dynamics of social inclusion: the attitudinal or value base of services, how the provider/recipient relationships get played out, the power dynamics, and how these impact upon whether services have the potential to support inclusion or not.

I am interested in the extent to which mental health services have somehow managed to remain hardly touched by the kinds of pushes for anti-discriminatory practice that have been developing in other areas of provision over the past twenty years. That people can say in all seriousness that inclusion is the latest “fad”, or “new thing”, and that we can take bits of it on as it suits us, are examples of comments that in themselves demonstrate an isolation or aloofness of mental health services from wider developments in practice.

In this paper, I attempt to begin to explore some of these issues; I will look briefly at the extent to which social inclusion is about “services” (as we know them) at all, and whether we need a radically different approach. Here, I’m not trying to lay down a new set of fixed rules, but rather to open up mental health practice to new thinking and awareness of some of the less conscious dynamics that are present. If this goes some way to initiate or support dialogue and thinking – which themselves inevitably effect practice - the observations will have been worth putting out.

Some stories:

At times of change, when a whole orthodoxy is challenged and held to account, it is both understandable and not unusual for the system under challenge to find ways of taking back control, making the new ideas its own. This process is underway in mental health,
and the system is beginning to provide its own reactions and responses to what it tends to
dismiss as a relatively new and ungrounded ideology. Some stories that seem to be taking
root about inclusion are: that it is but one of a range of service options or choices; that it is
largely about the location of services; that it isn’t for everybody; that it cannot/should not
be imposed upon people; that there is too much discrimination and stigma for people to be
included yet; that it is all a government drive to force people into jobs and save money.

Whilst it can often be hard for those working within services to be able to own and
embrace externally-driven service changes, without taking on the implicit criticism of their
current practice, it is important to address the arguments and not leave them somehow
unmentionable for fear of causing upset or a defensive reaction. Some of these stories
were very competently tackled by Peter Bates in his short paper “Accidents at the
inclusion traffic lights” (Bates, 2005), and here I’d like to look a little further into some of
the apparent reasons why social inclusion cannot (or should not) work for everybody
(particularly those with serious mental health problems).

A starting place:

For me, social inclusion is not a tangible thing as such. It is certainly not a thing that is
done to people, nor a service type, but a state. It’s about how we live in the world and how
we have a right to freely make our choices and experience them. It is a state that people
ambivalently, and often uncomfortably, live in. It is often difficult; it can be full of
disappointments and unpredictability, with times of struggle, loneliness, unexpected
changes, upset, grief and boredom. It can be full of interest too, moments of joy,
excitement, spontaneity, creativity, freedom, friendship, connection, choice, relationship…
It is life. It is certainly not appropriate for some but not for others.

It seems important here to acknowledge that the notion of inclusion, which itself comes
from an analysis of exclusion, is not new. It comes from the recent work in the 1980s and
90s by the disabled people and equal opportunities movements, which themselves took
much learning from the Black civil rights and Women’s movements and other struggles for
equality. It’s interesting how the ground shifts over time, but still the same arguments are
used to very clearly assert why a particular group can’t or shouldn’t be a full part of
society. Women, Black people, disabled people and others, have all taken centre stage
over the years. In some respects then, the very caring, professionalised arguments
(characterised above) need to be addressed, partly for damage limitation, but largely on
an emotional level as much as for their content.

Some thoughts on expectations:

I’m always both shocked and fascinated at how the mental health system (not unlike other
systems in the health and social care professions) has needed to create such a stark gulf
between the providers and users of their services. This is particularly stark for me when
considering expectations and ambition – on the one hand what service providers expect of
their service users, and on the other what they expect for themselves and each other in
their own lives. It is becoming increasingly researched and documented that services
seem to find it very hard to imagine their service users as employable and able to live
without them.
It is a difficult one to talk about and yet, somewhere, it seems to lie at the core of this issue. For me it represents the starkness of the difference, the line that divides – if “they” were like “us”... well, who knows, is it that “we” might not be needed, or might need to revisit our career motivations or at least what we’ve learned about the nature of “mental illness”. Or is it perhaps that it places too much of a challenge to what can be imagined about the possibilities of different lifestyles.

These low expectations get played out particularly around the issue of employment. In a society that has historically had quite a rigid employment culture, it has, I suggest, unfortunately become the thing that carries much that is bad in the “normal” world – work has come to equate to poor mental health, stress, discrimination, inflexibility, loss of identity. This flies in the face of much current evidence, which is showing that it is unemployment that correlates much more with these factors than employment.

**Doing it in different places:**

There are various models and “tools” emerging to aid understanding of inclusion, the (Bates/NDT) traffic lights model probably being the most well known of them. The model frames mental health services provided in mental health locations (eg day hospitals, day centres) as "red", services taken out into mainstream locations (eg a college or community centre) as "amber", and mainstream activities which are open and supportive of people's full involvement - or when people are specifically supported to engage in the mainstream - as "green". Unfortunately though, a model that was always intended as a very simple sketch to help to understand some locational issues in relation to inclusion has become fixed in its reception, and all kinds of truths have become formed around it. This seems to indicate a rigidity, a desire to fix ideas and practices, and a need to reduce complexity and subtlety to a set of improbably simplistic truths.

One of the truths that has emerged is that people need to move from red services, through amber, to green. Another is that amber services are better than red, but safer than green ones. These new “facts” give permission and misguided justification for a set of practices that all too often go unquestioned.

My own understanding of the traffic lights model is that it suggests no particular direction of travel associated with the locations of activity; rather it describes what is. If, for example, there hadn't been a propensity for taking services out into mainstream locations, then there’d be no need to include an "amber" traffic light. The model doesn't argue a need for amber services (on the way from red to green), it merely describes that they exist. Neither does it make any claims for the need for red services, nor that they are a good or necessary preparation for partly-inclusive "amber" ones.

**The stigma of Pseudo-inclusion:**

The idea that social inclusion is largely about location, the where rather than the how services are delivered, seems to have gained a currency that will, I fear, undermine the possibility of really finding out what inclusion for mental health survivors and service users
might look like. How easy it is to merely carry on doing what we’ve always done, only in a
different place.

I began to argue in a previous piece (Popperwell, 2006), that to merely take a service out
into the mainstream and call it inclusion, can actually perpetuate & reinforce stigma and
discrimination. The trouble for me is, that to give public exposure to much of what goes on
in mental health services, and to expose too the relationships between staff and service
users, makes too public a whole dynamic that doesn't belong in mainstream view.

Sadly though, it’s happening and with little thought and attention. So we
now increasingly
have overly large groups of people, often with little in common with one another (other
than a partly shared experience of service use) using cafes, where one or two people in
the group have a noticeably different role: they might issue money before they go in, they
might pay for the drinks, and they do talk a different language and in a different way to the
group. We have classes taken from day centres out into community centres that are
apparently intended to bridge the gap from segregation to inclusion, however I’d argue
that they are more likely to expose people as dependent and different, only engageable
with as a group and often through a worker.

What’s being missed in all this is that the “fact” that to move straight into mainstream
services is apparently dangerous has not been properly explored. It is based upon either a
set of assumptions or only knowledge of historic, poor, non-inclusive practice. All the
evidence emerging seems to be that, if respectfully treated and properly supported, going
straight into the activity works, whilst a slow transition merely prolongs the anxiety.

The challenge here is, I think, to explore and promote new ways of working in mainstream
locations. Whether this is best done by mental health workers, who often have a
therapeutic role in relation to service users, needs to be tested out. Certainly some staff
find these new roles more comfortable than others, and perhaps a new set of professional
values and associated training is required in order to be able to manage this. The extent to
which current service providers are really able to embrace the changes in values and
practice that will be required of them needs to be considered. I wonder if work in an
enabling, community-based, support role or broker of services requires an entirely
different kind of career motivation and set of personal values from those that services
have traditionally required.

**Protective services:**

The notion that, because there is stigma and discrimination in our society, mental health
services need to protect their service users from it until it gets better, is a deeply
concerning one. It sums up so well the benevolent discrimination that is present within
services, and in many ways it is that “benevolence” that makes it most hard to deal with. A
less than conscious paternalism, a helpful promotion of leisure lifestyles, a kindly
protection from disappointment and change, and a warm-hearted separation from the
world.

The issue here seems to be, far from keeping people out of the world, about assisting
them to gain more of an active relationship to stigma and discrimination – getting together,
supporting each other, being enraged about it, taking action. Equally, in terms of stigma,
rather than services misguidedly thinking that they can truly protect people from it, they might more usefully support them to gain a more robust relationship to it. All the evidence from other groups that face discrimination is that it improves with greater presence, but it doesn’t go away. The “protection” of people in itself is probably inadvertently prolonging the stigma. Who knows what our society might be like had all the experts been taken seriously in terms of who would have best been kept out (for their own or for the "greater" good)?

Support:

The role of support and facilitation is emerging as a potential new and empowering way of working with people. This is maybe a positive way forward, however, without a new awareness of the subtleties of what their interventions are doing, staff might well fall into the traps described above.

How support can operate without creating unhelpful levels of dependency, how we can discover new empowering ways that enable people's living of their chosen lives, is the challenge for services over the next few years. It can only start with an acknowledgement of the dynamics. It may be that mental health professionals are not the most appropriate workers to support people into employment, college courses, leisure activities and so on; if this is the case, then mental health staff need to be very clear about their roles in supporting their service users' inclusion.

The experiment:

I really don’t pretend to know what mental health services that are truly supportive of people’s inclusion might look like in the future and resist predictions. Of course I have some ideas about what they should be doing, although I have more of a picture of what the “mainstream” needs to do in order to include people and support all kinds of participation. To fix a picture of services and project it into the future would certainly help our anxiety levels and our relationship to unpredictability, but it would be unlikely to be helpful and hopefully would be far from accurate.

I guess what we need to do is, in partnership with service users, embark on the experiment together, or more usefully, embark on a whole series of experiments. We need to discover what the role of mental health services might be in relation to people living their lives, and to find out through action research programmes, what an inclusive society might be like.

This needs a degree of confidence, a spirit of hope, not needing to know the answers, a willingness to make mistakes, and to try again and again.

References:


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