The place of the social dimension in mental health recovery and social inclusion work

Shula Ramon

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s.ramon@herts.ac.uk

The complexity of the social dimension

- Layers of the social dimension :
- Interpersonal relationships and interactions
- Group relationships and interactions
- Community relationships and interactions
- National relationships and interactions
- International relationships and interactions
- Within the social dimension there are further facets which include:
- socioeconomic status, attitudes to people experiencing mental ill health, living in poverty, policy decisions on type and level of support to people with the lived experience of mental ill health, including financial benefits and eligibility; the type of services and the direction of interventions; decisions on legislation to include coercion and protection; decisions on the social importance of professional disciplines and their contributions to the field of mental health; decisions on the value of lived experience at each of the layers.

Complexity II

- The layers and the facets attest to the complexity and intersectionality of the social dimension, which usually is dichotomised into the macro, meso and micro sub-dimensions.
- All relationships and interactions at the three levels are largely determined by society, though there are windows for individual agency and for applying social processes of change.
- Power and power differentials also play a part in determining course of action.
- Social capital is a relatively new perspective of conceptualising strengths, weaknesses, opportunities and barriers to utilising opportunities, which has a place in the recovery approach.

Innovations in the application of the social dimension in recovery

- There are several important innovations which are inter-related to the application of the social dimension within the recovery approach. These include:
- 1.Social recovery
- Although we engage in cost effectiveness where income and social activities are part of the menu, we do not engage in the balance between medical, personal, and social interventions, despite our knowledge that rates of social recovery depend on economic trends much more than they depend on medical intervention, or on innovation in medication (Warner, 2004).
- 2.The training and employment of peer support workers.
- 3.The Connection Project developed by Martin Webber in the context of networking and in the light of the social capital approach, is rare and its replication is even rarer.
- 4.The development of the Open Dialogue : a mixture of systemic family approach with an intuitive SDM approach within a framework that provides secured continuity for a defined period of well trained professionals, yet offers a flexible approach as to where and when meetings take place, as well as in the selection of participants in a given network. This is an example of a social approach at the meso level, and of co-production.
- Although our mental health services are impacted by an unending process of organisational change and seem to be in a permanent demoralised state, those working in the Open Dialogue teams express mainly positive satisfaction. We need to ask ourselves why does it have the success it had, even in the UK, which has done much less well re employment and care management?

Innovation II

- 5.The Hearing Voices network: another example of the value of shared and mutually supportive groupwork, in this case based largely on lived experience knowledge , demonstrates the added value of learning from the lived experience and the negative impact of the taken for granted value of medication. This meso intervention has clearly a social dimension.
- 6.The recovery colleges
- 7.Personalised budgets (Hamilton et al, 2015)
- 8.Employment initiatives (IPS - Individual placement support)
- 9.Systematic attempts at stigma reduction.
- 10.A blessing, though not an innovation: We should also not forget that having a public mental health service in which there is no payment at the point of receiving treatment is a huge plus, especially when compared to the lack of such a system in the richest country in the world.
- 11.Knolwedge innovation
- a.Recognition of the value of knowledge based on lived experience of mental distress and ill health
- While usually referred to as individual lived experience, the collective lived experience is potentially more powerful in being verified as intersubjective knowledge vis a vis scientific knowledge
- The newly found focus on the value of the lived experience represents an interesting development in terms of valuing different types of knowledge. For the first time experiential knowledge is valued as a positive contribution to our knowledge, and its collective dimension as adding validity to it.

- A number of **critical sociological approaches** are not only critical of the current mental health system as reflecting a sophisticated approach to social control (Foucault, Giddings, Goffman). They also do not believe it is possible to change the tendency to secure social control in any society or in any individual life trajectory. Thus the possibility of emancipation or empowerment is perceived as non-existing within these strands of sociological theory.
- Consequently they either do not recognise the recovery approach as having the potential to enable real life choices for people with mental ill health, or see it as another neoliberal sham.
- I am for **co-production** in the context of mental health because the lived experience and the professional facet, as well as the organisational system are socially constructed. Coming from a primarily social perspective, does not necessarily negate the value of the personal perspective. The latter too is to an extent socially constructed through socialisation, relationships and interactions which also have a controlling element, though all three leave space for personal choices and decisions.
- Co-production entails the co-existence of different groups without necessarily assuming equality in status. It contradicts the notion of any one group controlling another as the key to more in-depth and more comprehensive development of each group and individual members of each groups.
- The centrality of **interdependency, rather than autonomy, in our lives**

On the negative side we have:

- **Loss of positive past components:**
- The UK had a well development community work strand prior to the period in which Mrs. Thatcher was the prime minister, created by Labour governments in the 1960s. She has dismantled all of it, including the bit that existed in mental health, on the grounds that it was not deemed effective as much as individual work, and it has not been resurrected by New Labour.
- It also had a lot more family and group work within the public sector
- Presently little attention is being paid to the social dimension at the level of mental health interventions in the UK public sector. For example, although people live on the wards in groups, as well as in supported housing, little – if anything – is being provided by way of groupwork. It is left largely to the voluntary sector to provide an element of groupwork and of solidarity, though the relatively new Recovery Colleges offer a varied measure of solidarity, and often utilise groupwork methods in their training programmes.
- Although we engage in cost effectiveness where income and social activities are part of the menu, we do not engage in the balance between medical, personal, and social interventions, despite our knowledge that rates of social recovery depend on economic trends much more than they depend on medical intervention, or on innovation in medication (Warner, 2004).

- **Living in poverty** is known to have highly negative effects not only on living standards and physical health, but on self esteem, ability to participate in ordinary social activities, and as a source of constant stress and humiliation. Yet this element does not receive much attention in either the research literature or in interventions.
- Furthermore, in the current UK welfare climate, people who live on benefits are demonised as "scroungers" even though the level of fraud in such benefits is reported to be 0.7% of the total spent on benefits.
- The assessment procedure for benefits entitlement are degrading and are on the whole unsuitable for people experiencing mental ill health. The level of benefits is couched below the average cost of living, based on the assumption that if it would enable people to lead a decent quality of life this would demotivate them to come off benefits.
- Thus those who are negatively impacted by mental ill health are then also exposed to the stigma attached to being benefit receivers. These attitudes are socially constructed, and changing them requires a socio-political strategy.
- Alain Topor and his group (2016) justifiably talk about this duality as coping with **double trouble**.
- **This was written before I saw I Daniel Blake!**

- **Stigma:** Although the Time-to-Change project provided a considerable push towards stigma reduction by using social marketing approaches, it is unclear how sustainable is the reported change. Some of the findings call for a social perspective explanation, which thus far has not been provided. For example, while general public attitudes have become less negative towards people experiencing mental ill health during the project years, those of mental health professionals have remained as negative as they were initially.
- Courtesy stigma continues to be attributed to family members and to those who handle access to financial benefits and housing.
- **Power relations:** Our mental health service system continues to give a lot more power to some professions , and to professionals in general, than it does to people with the lived experience of mental ill health. This is clearly expressed in the decision making sphere, and impacts all interventions, much beyond the decisions to hospitalise people against their will.

Neoliberalism and the new meaning of recovery

- The treatment of neoliberalism as only a controlling system is another example of being ruled by one's feelings. It is not difficult to be aware and disapprove of the limiting value of the uni-dimentionality entailed in the neoliberal approach and the high level of exploitation embedded in it , namely the belief that economic profitability is the only value and commodity that matters – it is not only wrong morally, but also patently wrong at taking account of the multi-layered society in which we live, and runs the risk of denigrating humanity. However, to jump from the refusal to accept neoliberalism as a worthwhile ruling principle of our reality to negating any positive developments related to the relaxation of rigid rules concerning employment is misleading. For example, peer support workers would be an unlikely outcome of a more rigid system.
- To argue that the recovery approach is a product of Neoliberalism is to confuse support for taking personal responsibility for oneself with abandoning people.
- The growing social recognition of **hybrid identities**, strengths and weaknesses of each of us and in particular of groups with a "spoiled" or stigmatised identities, as exemplified in terms of gender and sexual orientation identities, is reflected in relation to peer support workers, where dual identity is taken for granted. This is an example of relaxing rigid rules concerning the crucial area of identity.

Towards a new framework of understanding the role of the social dimension in recovery

- Tew (2013) is proposing an elaboration of what recovery is to include the enhancement of personal efficacy and of social capability. He defines recovery on the one hand as being able to lead a full life, one of contributing as active citizens, and on the other hand as depending on the resolution of internal distress (personal recovery) alongside social re-engagement (social recovery).
- These dimensions are justified in particular in terms of the sustainability of recovery, accepting that their implementation may require a longer term than that of medical intervention. The latter assumption seems to me to be in need of research, as while medical interventions reduce symptoms in the short term they also often come with adverse side effects that are not short term.
- Capability is further defined as having a range of positive choices and opportunities within one's social context for "a life worth living", in which the person does not remain on the margins of society. This does echo Durkheim's claim that anomie leads people to suicide.
- Tew perceives of recovery capital as including economic, social, identity, personal and relation

Investment in social research

- We in the UK invest much less in researching the social aspects of recovery – and of mental ill health and health in general – than we do in medical and psychological interventions. This is attributed in part to the assumed lack of immediate positive outcomes, but primarily to the lack of belief in the value of social perspectives in this context, despite the existing evidence to the contrary.
- **The social dimension in recovery research**
- We do carry out research on the social dimension of recovery, though insufficiently so and often do not have clear cut findings as a result of such a research (Tew et al, 2012, part of the Refocus project). This is partly due to the inevitable intersectional aspect of the social dimension, and the need for mid to long term time span when researching the social aspect of mental ill health.
- However, even simple statistics such as those quoted by Wilkinson and Pickett (2010, p. 67) on the correlation between income inequality and rate of mental ill health and its significance for the degree of mental wellbeing, suffice to demonstrate the need for researching the social perspective. They highlight that countries with higher income inequality have higher rates of mental ill health, regardless of a higher level of expenditure on mental health interventions. Countries with lower inequality are doing better in terms of wellbeing and rate of mental ill health.
- Evaluation research of the more socially oriented interventions – such as the Open dialogue, Hearing Voices Network, the impact of being in employment, having a meaningful social network – demonstrate adequately the usefulness of the social dimension in enhancing recovery.
- The need for intersectional research (Ramon, 2015)

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