Community Connections and Creative Mental Health Practice

By Peter Bates and Sandra Butler

"Community recovery begins when the community and its leaders understand both the effects of mental illness and the societal impact of not delivering effective, efficient services. Recovery begins in earnest when the community and its leaders find ways to harness the potential contribution of service users in every aspect of community life." (Silvestri and Jue, 2002: p.32)

Introduction

There is a history of distrust between the people who use and those who provide mental health services. In spite of this, user consultation and empowerment have become critical themes in mental health, generating efforts to produce user-centred services, generally concentrating upon either training the users to help reform existing services or creating new organisations unpolluted by traditional values, policies and practices. There are alternatives to these options, such as training the traditional power holders to let go, creating new patterns of decision-making, or re-interpreting the notion of empowerment so that it relates to independent living rather than service design and delivery. It is this last strand that we pursue here by examining the development of community inclusion as a viable option for service planners in constructing alternatives to heavily congregated mental health services. The chapter uses the pioneering work of the Community Connections Project, Nottingham as a practice scenario...

Practice Scenario 5.1: Introducing the Community Connections Project

In 1993, the first author became increasingly aware of the failure of traditional psychiatric day services to tackle community inclusion. Day centres could be empowering and participative but they failed to build a bridge into ordinary relationships with citizens outside the mental health system. At that time the local further education college wanted to provide opportunities to people with mental health difficulties and appointed an education counsellor for a six-month trial period. Linking with one day centre, she gradually developed suitable pathways into college for numerous people, many of whom participated as individual students in mainstream classes. The vision grew to identify similar links into sports activities, cultural pursuits, and so on, with the model of Community Connections evolving incrementally (Bates, 1996). By 1998 the project had its own office base, was appointing its first full time team leader, building collaborative arrangements with learning disability services and had worked with over 300 service users and 50 community organisations. This work has been ongoing since then.

Consequences Of Using Mental Health Services

As mental health reforms have progressed it has become obvious that breaking down institutionalisation involves more than just demolishing bricks and mortar. Service users have been excluded from increasingly complex, multi-racial and multi-cultural societal contexts. As a result, they commonly experience a number of factors that constrict their social roles and sense of identity. Within the psychiatric system, the damaging effects of a strong patient identity and an unequal power relationship with staff compounds the problem. The focus on care facilities and care planning which prioritises survival needs and symptom management often avoids any recognition of users' strengths or their contribution to family and community life. Few expect or support users to take on positive roles in the community. In addition, the mystique surrounding mental illness, the community safety shroud-waving of the media, the mantra of confidentiality and the blaming of families all reinforce the illusion that professionals – and no one else – must deal with every problem encountered by service users.

Day services have been particularly slow to develop options that address equal opportunities and users' social exclusion. Their aim has been skill development, behavioural management and change of service users in a depoliticised arena where few centres have created multi-racial and woman centred environments. In response to this, African-Caribbean and Asian communities have developed their own autonomous, physically distinctive organisations as expressions of their aspirations, expectations and self-definition of their own experiences, while striving to fulfil the duties and responsibilities of their communities. Indeed, Black users have repeatedly asked for Black centres in user surveys (McGovern and Hemmings, 1994; Radia, 1996), as this provides an opportunity for mutuality and sharing (Sassoon and Lindow, 1995).

Whilst it is necessary to ensure that existing day services provide both Black and women only spaces and times, the establishment of a more community-based, individualised approach for everyone is long overdue. Irrespective of the quality of provision, long term mental health problems and institutionalisation are associated with a range of features that affect social contact. These include:

- self care, as neglected personal hygiene can offend others (Bates and Pidgeon, 1990);

- home management, as hospitality is a valued feature of friendship;

- unemployment;

- poverty;

- restricted use of educational and leisure facilities.

Relationships may well be characterised by dependency, damaged during acute episodes of disturbance, inhibited by low self-confidence and experienced as stressful. Institutional care is likely to offer a restricted set of models of appropriate behaviour (Goffman, 1961), severe role constriction (Estroff, 1989) and shrunken social circles (Brugha, 1991). Taylor and Huxley (1984: p.28) observed that the social networks of users with schizophrenia are small, especially in relation to non-kin

members. Network members are also poorly connected, having asymmetric relationships where others, rather than the service user, largely direct the relationship. Indeed, the picture is so depressingly uniform that Wilcox and Bellamy (1987) have asserted that people with severe disabilities will experience few relationships, these will most probably be of an impersonal and temporary nature, and that those contacts will be restricted to other users, providers or kin...

The Impact of Social Contact

Sociologists have attributed a range of problems to isolation, segregation and alienation – for example, House *et al* (1988) concluded that socially isolated people were twice as likely to die at a given age compared with those who enjoyed strong social ties. The Mind inquiry (Dunn, 1999) provides substantial evidence from service users to show the impact of discrimination and exclusion (see also Sayce, 2000). Psychiatric literature acknowledges the complex relationship between social inclusion and mental distress. Poverty and disadvantage deny people opportunities to develop and sustain community participation (Holloway, 1988), while relationships with family members, neighbours, work or leisure associates can provide a monitoring function, alerting the helping agencies when required. Isolated persons are without the benefit of this monitoring function and therefore problems remain undetected until they become critical (Hughes and Gove, 1981), while people with few social networks are at more risk of abuse. Psychiatric crises can precipitate withdrawal by others, and the social drift hypothesis (Hollingshead and Redlich, 1958) illustrates how, as episodes of disturbance fracture established lifestyle patterns, people move down the socio-economic scale and away from supportive relationships.

However, this is not an entirely uniform picture. Hughes and Gove (1981) also note that relationships with household members are not always conducive to positive mental health, and it may be better to live alone than with those who are too critical or emotionally over-involved (Leff and Vaughn, 1985). Some older people associate high levels of personal satisfaction with a reduction of social interaction (Taylor and Huxley, 1984) and, in some psychiatric diagnoses, relapse is correlated with an increase in social stimulation (Brugha, 1991). Despite these cautions, Brugha generally sees social isolation as a sign of illness and inclusion as an intervention goal, since it usually constitutes a buffer against the development of psychiatric disorder and is a crucial factor in determining successful survival in the community. Indeed, Burchard *et al* (1991) identify having a social life as among the most critical aspects relating to quality of life. Being locked out of community participation, therefore, has profound psychological effects...

So what is unique about the inclusion movement and why can it generate creative mental health practice? First, it is profoundly – perhaps naively – hopeful and celebratory. Whilst the proponents of inclusion are keenly aware of stigma and rejection, they tend to focus most of their efforts on people who will welcome others, and hope that good news will spread by example. They do not castigate people for behaving inappropriately towards those with disabilities, or view this as wilful oppression. Instead, they assume people are well motivated and offer training to enhance the community's capacity to welcome disabled people. In addition, the Strengths Model (Rapp and Wintersteen, 1989) assists human service staff to shift

from a problem focus to a concentration on the assets, capacities and positive achievements of both users and the community.

Secondly, person-centred planning approaches focus on the individual's dream of an improved quality of life and then work backwards ("What do I want? How do I achieve this? What support will I need?"). This contrasts with the traditional approach of human service professionals who assess the present and then plan each step forwards ("What is available now?"). Participants in the inclusion movement are united by a shared dream of a future where there is a place for everyone (Bates, 2002).

Thirdly, it does not distinguish between people labelled disabled or non-disabled. Instead, everyone is using their skills to work for a more inclusive world, where interdependency is valued and social exclusion is outlawed. Fourthly, inclusion is about friendship and validation by others, with an attendant emphasis on the centrality of relationships. The best inclusion projects (O'Brien and O'Brien, 1992) seem to be those where ordinary citizens value the person with a disability for themselves and are not particularly motivated by altruism. Finally, inclusion is a right, not a privilege. Inclusion enthusiasts argue that since society has been learning about social exclusion for two hundred years it will be a protracted process to end fragmentation, let go of disabling practices, and learn how to support people effectively (Asante, 1997).

Inclusive writers believe that there are potential roles and relationships in the community for people with disabilities and these can be located and unlocked by emphasising our common bond of humanity and interdependence (Mount *et al*, 1988; Beeman *et al*, 1989; Ludlum 1993). In the person-centred plan (Mount and Zwemik, 1989) self determination and relationships are prioritised with the objective of changing the environment and attitudes as a way of integrating users. Focused effort on the part of workers is directed towards increasing opportunities and choices for service users, rather than prescribing a certain kind of lifestyle or degree of social inclusion.

Community inclusion is attractive for its optimism about the capacity of ordinary citizens and those with disabilities to build mutual, valuing relationships with each other. This vision has fuelled efforts to provide opportunities for disabled people to integrate into activities such as further education, employment and recreational pursuits, and has affirmed the sociological hypothesis that, for many users, social isolation and role constriction is a consequence of the service rather than the person. ...the poverty of contact which is a feature of the lives of people with enduring mental health difficulties demands careful but determined action.

The Four Dimensions of Community Participation

We have demonstrated how community connections work is visionary and idealistic and this confronts social work with considerable dilemmas in bridging the gap between these ideals and practice realities. For mental health users in receipt of community care services, Figure 5.2 presents a framework of four elements to be used in assessing different kinds of contact with the community. These are not mutually exclusive, and a single activity may well include two or three elements, but it is helpful to think about them separately.

GOING OUT - leaving the residential or day care building for any reason.	COMMUNITY AMENITIES - places to shop, eat, drink, walk, look.
GOAL/RATIONALE - To enlarge experiences, develop interests, gain respite from other household members, acquire topics for conversation, add to collection of "safe places".	GOAL/RATIONALE - To develop independence in activities of daily living, to reduce use of specialist services, to develop existing acquaintances into friendships.
INTEGRATED PURSUITS - joining a group of citizens without apparent disabilities to work, learn or enjoy leisure time.	SOCIAL NETWORKS - relatives, friends, neighbours, colleagues who care.
GOAL/RATIONALE - To socialise into valued roles, to make acquaintances who have common interests, to pursue skills and interests with those people over a period of time, to develop an active life and support network apart from formal welfare services.	GOAL/RATIONALE - For companionship, practical help and emotional support, to buffer against stress and illness, to connect with a growing network of contacts.

Figure 5.2 - Components of Community Connections

Going Out

Research in this area has generally been applied to residential situations. For example, Firth and Short (1987) found that the number of outings and their duration increased by over 50% after people had moved from hospital to a community hostel. Adding a layer of complexity to this kind of study involves listing and perhaps categorising the destinations of the outings (Lowe and de Paiva, 1991). However, such a list tells us little about the *meaning* of those excursions to the person concerned. Outings of almost any kind can be enriching, enlarge the repertoire of topics for conversation, and stimulate interests. Organised visits, repeatedly using the same destination, can establish a sense of familiarity with the aim of adding these venues to an individual's personal map. Staff or other allies can often help in this field by assisting with the arrangements, providing transport, or serving as an escort.

Community Amenities

Some people highly value the contact they have with shopkeepers, hairdressers and others who staff community amenities. Saxby *et al* (1986) examined the way in which people with learning difficulties used shops and cafes and they offer the notion of "substantive participation" to describe actively engaging in appropriate behaviour in a particular setting. This would distinguish, for example, passively accompanying someone who was shopping, from an occasion where the disabled person was pushing the trolley, selecting items, offering money to the cashier and packing bags. A distinctive factor in these environments is the nature of contact with others. Although interaction with non-disabled people does take place, it tends to be

instrumental, brief and impersonal. However, people who already know each other might use these community amenities together to develop their friendship; acquaintances may go for a drink, walk in the park or spend an afternoon shopping.

Integrated Pursuits

While the use of community amenities is characterised by brief contact with other citizens, this element is concerned with longer-term membership of social groups. The pursuit might be remunerative employment, further education or a recreational activity and may provide a social role that is highly valued in the community. Those attending have some sense of group identity and are bound together by a common interest or activity, rather than a medical diagnosis. The role of a carer or ally may range from companionship to making introductions or repairing an activity when it appears to be in danger of breaking down. Both Evans *et al* (1992) and Schalock and Lilley (1986) note that disabled people sometimes achieve geographical integration by attending the same group as other citizens, but fail to integrate socially. It is therefore easier to create the illusion of inclusion than the reality.

Social Networks

Willmott (1986) analysed the frequency of contacts with relatives, neighbours and friends amongst the general population. He found that men had more contact with others than women; that African-Caribbean and Asian elders had less than average contact with neighbours; and that young people had more contact with friends than older people. However, support is a combination of both *quantity* and *quality* of contact. Tolsdorf (1976) examined the social networks of psychiatric in-patients and found that their relationships were less intimate than a comparison group. Furthermore, they were less likely to draw on network resources due to anxieties about the ignorance or insensitivity of network members. Silberfeld (1978) found that his group of psychiatric patients were in touch with as many relatives as the control group, but met them less frequently and spent less time at each encounter.

In contrast to these findings, Nelson *et al* (1992) examined the networks of a number of people who were receiving psychotropic medication and found considerable evidence of reciprocity in relationships. Transactions between patients were characterised by a higher level of emotional support than relationships with relatives or professionals. Relationships with kin, neighbours and associates confer a sense of identity, value and role. Allies can use a wide range of strategies to support people who wish to expand branches of their social network, increase the degree of intimacy or replace negative exchanges with more positive ones. Community inclusion cannot mandate or legislate for intimacy (Asante, 1997), but it can create the preconditions from which friendships can emerge.

Adopting an inclusive approach is a valid approach in an age of shrinking welfare expenditure, as it transfers some of the professional support to unpaid informal systems, with a concomitant need for professional humility...

In urban areas with reasonably good transport systems, it is possible to slice the community by topic, such as employment, education, volunteering, arts, faith and cultural communities, sport and exercise, and local neighbourhoods. For instance, one worker can become knowledgeable about employment and build relationships with the Chamber of Commerce, the Jobcentre and so on, whilst another worker can investigate cultural opportunities. These life domains (see figure 5.4) provide a focus for worker and user alike, enabling marketing to be targeted, referrals to be made, and achievements to be recognised. As projects progress, the life domains can be split and re-combined as new staff arrive and others leave. Community Connections work can be co-ordinated across a range of mental health settings using dedicated staff time, where a percentage of the working week is allocated to life domain activities. Such a strategy demystifies this approach, reduces the risk that it will be dismissed as idealistic and unachievable, and prevents this developmental work being squeezed out by short-term activities (a risk implicit in the changes and pressures on social workers which were identified in Chapter 2). A team approach is needed to ensure that learning gained in one life domain is shared with staff and users engaged in other domains.
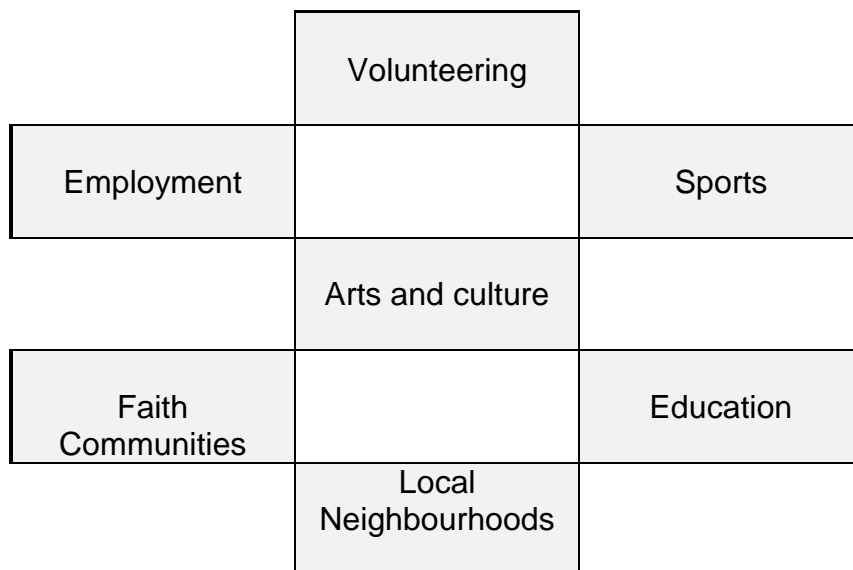

Figure 5.4: Life domains

Community Connections interventions are akin to community development work in the voluntary sector, as outlined in Chapter 4. Indeed, the voluntary sector is well placed to contribute imaginatively to the totality of users' life domains because small-scale community projects often have a better sense of locality than the monolithic psychiatric system. Inclusive values and devolution of power to service providers and users are in harmony with social work values, although many experienced practitioners may need to re-learn under-used skills.

Practice Scenario 5.3: Stages of Development

The Community Connections Project involved three stages of development:

- In Phase 1, faced with a unique practice situation, ideas developed out of reflection, conceptualisation and active experimentation. The Project rested on the energy and enthusiasm of a small number of key people acting as instigators, with supplementary help arising out of goodwill gestures by others. This was a loose network with a limited capacity to resolve conflict, agree on a common direction or guarantee quality. Marketing of the Project was intense in order to secure support and resources.

- The pioneering work in this phase provided the launchpad for Phase 2 when staff were employed to work within the Project. Individuals were selected, trained and then managed in order to build a team that delivered high quality work to service users.

- At this point Project staff could look toward Phase 3, when the roles will be well established, support networks in place, and community Bridge Builders employed by host organisations in each life domain as part of their access and equal opportunities support.

In order to maintain community links and ensure that staff are accountable for their work a transparent structure needs to be set in place. Reflective practice necessitates more democratic forms of organisation where users have a direct input in policy formation, the mechanisms for consultation and participation are clear (Shaw, 1997), and users have maximum ability to define issues and identify appropriate action (Brandon, 1991; Braye, 2000). This entire process is characteristic of professional reflexivity (Taylor and White, 2000), a highly developed capacity to reflect on the implementation of change and adapt the processes accordingly.

In view of the pioneering nature of this work, there are few eclectic projects across the U.K. Some comparatively restricted projects work:

- in a particular life domain (for example, offering cultural opportunities to mental health users in museums and art galleries – see Dodd and Sandell, 2001);

- with a specific user group, such as people with learning disabilities only (McIntosh and Whittaker, 1999);

- with a particular strategy for inclusion, such as jobcoaching (Rusch and Hughes, 1989) or 'circles of friends' (Bates, 2000).

The limited range of opportunities is exemplified by available volunteering projects. A few Volunteer Bureaux offer specific support to people with mental health difficulties,

and many of those are dependent on short life funding. The majority view marginalised groups as potential recipients of voluntary effort, rather than as possible sources of volunteers, with communities and users being mutually enriched by the experience (Bates, 2001).

The fragmented pattern of project development points to the multiple dilemmas involved when steering a course through the unsettled waters of short life funding and organisational politics. Nevertheless, enacting inclusion principles in diverse and flexible ways symbolises the creativity involved, further illustrated by the Bridge Builder's practice skills and qualities.

Role of the Bridge Builder

The worker for each life domain adopts a role as a Bridge Builder (Mount *et al*, 1988) and may be employed by agencies other than health and social services. Her/his job involves exploring the particular life domain, locating allies, developing a strategy and offering pathways into that area of community life to users. Bridge Builders work as both 'travel agents' and 'travel companions' (Deitchman, 1980). Travel agents know what is available in the community, provide comprehensive information about opportunities and occasionally create new locations, while travel companions accompany the person into community settings. For socially excluded people who have engaged in demeaning or self-destructive behaviour, supporting the placement will include assisting users to learn appropriate behaviour in organisations where they will not be judged as morally inferior if they make a mistake (Davey, 1998).

Agencies have to learn new things too. One study of supported employment found that the traditional inequalities were being played out in the new 'inclusive' locations of ordinary jobs in ordinary workplaces. Women, who were placed in traditional sectors of food and clerical services, typically worked less hours and at a lower hourly rate of pay than men and had less positive relationships with their co-workers than male supported colleagues (Olson *et al*, 2000).

Travel agents and travel companions need to vary their strategies for individuals across life domains. For instance, the negotiating skills required in the education life domain, where the Bridge Builder may be working with large further education colleges, will be vastly different to those needed in small community groups in the local neighbourhood. Therefore, it becomes essential to catalogue available strategies, identifying the skills that maximise their success as well as the hazards to be avoided. For example, one user joined a local Residents Association with a worker who believed that his role was to provide intensive support at the beginning and then taper away, leaving the user attending the group independently. Unfortunately, this was not explained clearly enough to the user at the outset, and, in his eyes, the worker modelled poor commitment to the group. As a result, the worker's withdrawal from the group was shortly followed by the user's. This demonstrates how crucial it is for Bridge Builders to meet periodically in order to report progress, gather stories, swap strategies and celebrate success so that they develop competence and confidence....

McKnight (in O'Brien and O'Brien, 1996) lists a number of paradoxes for community Bridge Builders, including being professional and using sophisticated skills whilst

promoting a view that ordinary citizens can make an invaluable contribution; and working oneself out of a job. Because the role of Bridge Builder requires grappling with the dynamics of oppression and discrimination (highlighted in Chapter 1) and the internalisation of stigmatised identity, the effective practitioner must be capable in these areas. For example, in wrestling with the challenge of tackling racism and sexism, competent Bridge Builders will create pathways into Black or women-only settings.

The focus on community connections challenges Bridge Builders to re-think the notion of professional distance as they face issues that engage the heart as well as the head. They must also build access to faith communities and demonstrate respect for users' spirituality, which requires:

- The capacity to listen to the service user's history and current faith experience;

- Willingness to explore the universality of spiritual questions;

- Sensitivity to the range of meanings ascribed to psychiatric diagnosis and recovery by various faith systems;

- Knowledge of the most effective ways of harnessing goodwill within each faith community

(Mental Health Foundation, 2000).

The Bridge Builder therefore has a complex and difficult set of tasks. Indeed, as is also implicit within the work settings outlined in chapters 7 and 9 in this volume, there is no guarantee that social work training would be seen as a requirement for this role. However, there are numerous reasons for this task being best undertaken by social workers as service providers, or as co-ordinators of community connections projects.

- There is a need for a high level of sensitivity to anti-oppressive practice and empowerment values in community connections work. Social work is the only training amongst the caring professions that focuses on this topic (CCETSW, 1995).

- The knowledge base draws heavily on community development theories, requiring a thorough assimilation of community resources, and having an overview of users' structural and societal contexts, alongside co-ordination and negotiation skills. These areas are traditionally the province of social work, placing them in a strong position to respond to social exclusion (Washington and Paylor, 1998).

- Mental health social workers use systemic thinking to assess users' quality of life and undertake risk analyses (DoH, 1994). Smith (1993) reports a difference between social workers and health professionals in their approach to risk taking, with Ryan (1996) observing that risk is often viewed negatively by health practitioners. In addition, they bear formal responsibility for their judgement in matters concerning the safety of both the individual and the community, especially in work related to the Mental Health Act 1983, to a

greater extent than any other discipline except psychiatry. This combination provides a secure foundation for the innovative work of building inclusive communities.

However, the field is open to pioneers from any discipline who have vision, courage and perseverance. Evidence from early British experiments shows that most work is being developed by people whose common bond is that they share ideals, optimism and determination, rather than a particular academic or employment background...

Ethical Dilemmas in Community Connections Work

Given the contested nature of this form of intervention, the life domains perspective helps to escape the trap of perceiving locality as the only valid concept of community. It also takes us straight to the heart of three key hazards: inclusion as assimilation, as subjugation, and as containment.

First, inclusion does not mean assimilation. In the 1990s, efforts were made to include multi-culturism in disability services (Baxter *et al*, 1990; O'Connor, 1992, 1993; Traustadottir *et al*, 1994) after recognising that community integration had been implemented using an assimilationist framework (Racino, 1994). When arranging a community opportunity with a user the goal is more than assimilation. At one level, the service user may need to learn appropriate behaviour in order to 'fit' into the placement. In order to meet this target, s/he may be tempted to deny her/his experiences of mental distress in order to 'pass' as non-disabled, or to see themselves as a lone champion for the rights of service users and so feel permanently exhibited. The insidious and damaging effects of an assimilationist approach are readily apparent. The host environment therefore needs to change to become enriched by the addition of new experiences and interpretations brought by users, with a view to embracing and actively fostering diversity and celebrating difference.

Secondly, inclusion is not subjugation. There is an implicit belief that inclusive projects will be intuitively responsive to minority ethnic groups and women, but qualities of friendliness and welcome are not enough to overcome structural inequalities and social injustice. What do community Bridge Builders do when offered a placement which positions the user in a powerless role, but reflects where other disabled people, women, or Black people are likely to be found? The Community Connections project could become so focused upon achieving placements for users as volunteers that only traditional placements for women are forthcoming, for example. By adopting the macro perspective outlined in Chapter 1, oppression in all its forms can be recognised and challenged.

New forms of decision-making need to be harnessed so that users are not excluded from positions of influence in the organisations they join. This relates to users learning the skills to participate in communities, service providers changing the decision making machinery and service managers widening the decision-making arena. One of these mechanisms is groupwork (Butler and Wintram, 1991), which has been vital for Black men and women's consciousness-raising and politicisation. Bridge Builders therefore need to offer support to everyone and particularly women and Black people real choices based on positive action principles. Otherwise, service delivery will be hallmarked by the same patterns of paternalism inherent in

congregated services, which will then be translated in an unreconstructed fashion into the community.

Thirdly, inclusion is not containment. It offers a range of new roles and relationships for service users that transcend the traditional and controlling patient or client status. Users are perceived as citizens first, people who bring the richness of their human experience to the wider community. Professional norms have to be re-worked as users begin to make real friendships with neighbours, fall in love at work, or argue with the manager of the local community centre. All of these events create a dilemma for the traditional concept of user/professional relationships, which therefore have to be renegotiated...

In any inclusion project, the dilemmas surrounding confidentiality are clarified incrementally as workers and users confront particular practice scenarios. Reflection-in-action recognises that maximum experiential learning is generated through facing up to the mistakes, the unique practice situations which challenge traditional organisational responses.

Conclusion

In this chapter, we have demonstrated the deleterious effects of exclusion on people's mental health and made a case for designing services that offer users the opportunity of social inclusion. Having constructed the arguments for the participation of mental health service users in community life and activities, we have recognised the barriers that confront users and service providers alike in attempting to include users in community-based pursuits and social networks. By presenting a model of community participation, we have sought to capture the dilemmas and nuances of the inclusion movement, with a view to articulating how reflexive processes can be utilised to create an innovative, creative mental health project. Community inclusion work draws on idealistic dreams and values, and translates these into the small, incremental steps of practice realities, transforming users', workers' and community placements' lives in the process.

The context has dramatically changed over the decade since this project was pioneered. While the Government is contemplating more restrictive legislation to replace the 1983 Mental Health Act and additional beds are being set up in secure units, there is a simultaneous drive to promote inclusion. The Social Exclusion Unit is working on a major project to identify and harness the efforts of all Government departments to combat the exclusion of people with mental health problems. Within mental health, the lack of formalised duties in respect of day care is allowing funds to be diverted into alternative services that are deemed to be essential, and, at the same time, there is widespread interest in the community connections approach. There is a clear tension within government policy; as the choices become starker, the consequences of these decisions for service users become more explicit.