Emerging themes are a series of papers drawn from the work of the National Development Team

Triangles of support:

Creating relationships that support social inclusion

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Summary
The goal of social inclusion underpins Valuing People, but it's also a strong theme in government policy for people with mental health problems and other disadvantaged groups. Social inclusion requires, amongst other things, that specialist services change the way they offer their expertise: adding to, rather than replacing, the services that are used by ordinary citizens.

Recent work by the NDT for a specialist health provider made us look more closely at the relationship between specialist and mainstream services, and the qualities that are likely to make the relationship successful. This resulted in a way of thinking about the relationship that we've called 'triangles of support'. It's a very general model, and it's interesting to use it to think about a wide range of working relationships, within and beyond health and social care. But we think it also leads to some useful, and very practical ideas, about how to improve services for people who have learning disabilities or mental health problems.

In the first half of the last century it was generally assumed that people with learning disabilities or mental health problems could not, or should not, use the same public services as everyone else. The result was a system of 'special' public services that ran in parallel to the services used by other citizens. Children with special needs went to special schools. When they grew up they went to sheltered workshops or day centres. If they needed accommodation, they didn't get offered housing from housing agencies. Instead they went to live in institutions run by health services, or residential homes provided by social services. And, for a wide range of health needs, people were quickly routed away from ordinary community services and general hospitals.

In spite of some real progress over the last thirty years, that parallel system still lingers in the pattern of services we have now. But the government-backed principle of social inclusion places an obligation on services – and that's on both the specialist and mainstream sides – to get rid of it. Ordinary services must learn to include people who have 'special needs' alongside other citizens. The required role of specialist services is to help the ordinary services to learn the skills they need and, when necessary, to provide their expertise within the mainstream services: not *substituting* different services, but augmenting those which exist already. For example:

Need or problem	The old way - *substituting*	The new way - *augmenting*
Special educational needs	The child goes to a separate special school	The child receives extra help in the ordinary school class
Day activities	The person goes to a day centre	The person is supported in ordinary employment or community facilities
Challenging behaviours	The person is admitted to a specialised challenging behaviour service	Challenging behaviour specialist support social care staff and other citizens to work with the person
Sensory impairment	The person is referred to a clinic for people who have learning disabilities and sensory impairment	The clinic that provides a service to ordinary citizens who have sensory impairments acquires the skills to work with people who also have learning disabilities.

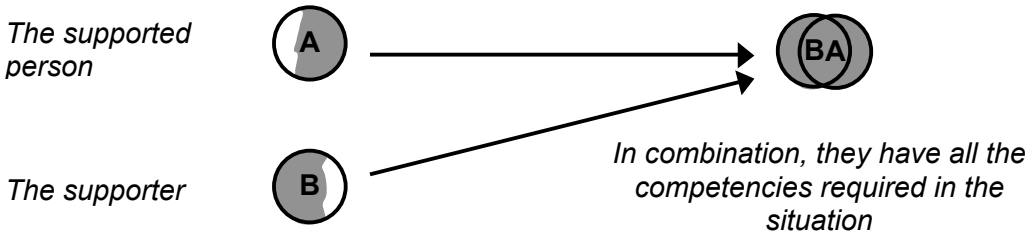
These examples make it clear that we're not concerned just with the single issue of specialist services working with, and within, mainstream services. The example of the challenging behaviour service shows that it may be a relationship between a specialist service and an even-more-specialist service. What we're looking at is a general kind of relationship in which one worker or service gets support from another worker or service. Typically the extra help comes from a source which offers a higher level of expertise.

So what's the nature of that relationship? And how can it be made to work so that it produces mainstream (or less specialised) services that have the competence and capacity to include all citizens? To answer that question, we went back to the beginning, and looked at what's meant by 'support'.

The nature of *support*

Reduced to its most basic, people need support because they lack the ability, knowledge, or skills that are required in a particular situation. They might lack the physical ability to reach for the drink on the table next to them, or the awareness of traffic to be safe on the streets. They might not be able to cook a meal for themselves. Or, to take a different kind of example, they might not have the expertise to diagnose and treat their own illness.

The gap is filled by introducing someone into the situation who possesses the missing knowledge or skills. This person doesn't necessarily have all the competencies required in the situation. The visiting support worker may know how to cook, but not where the local supermarket is. The doctor knows about illnesses, but needs the patient to explain the symptoms. However, *as a combination* they have all the competencies required to deal successfully in the situation. The diagram below shows this idea visually. (Incidentally, let's be clear that we're concerned here with incomplete competencies, not incomplete people. We all encounter situations where we don't have all the competencies that we need to cope alone.)



Support versus *Care*

So the supporter, B, brings their competencies to assist the supported person, A. However, the terms on which they offer the competencies – the relationship between A and B – can vary. A few years ago there was sudden shift in the terminology used to describe staff who assist people with learning disabilities. They stopped being called *care workers*, and became *support workers*. The reason – though it's now all but forgotten - is that care and support were considered to suggest very different attitudes. *Support* is enabling, whereas *care* is paternalistic. These contrasting attitudes translate, of course, into the aims and behaviours of the supporter within the relationship. The table below suggests some of the main distinctions.

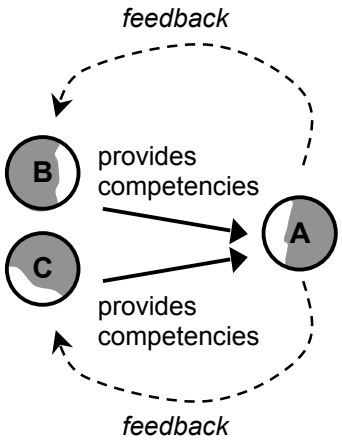
The relationship between supporter and individual:	
'Care'	***'Support'***
Presumes that the person cannot acquire competencies.	Believes in the person's capacity to acquire competencies
Aims to *substitute* competencies.	Aims to *augment* competencies
Where help is given, control is taken away; disempowering.	Control left with person wherever possible; strives for empowerment
Judges the person's competence level, then delivers fixed level of substitute skills.	Monitors the person's performance, and adjusts input up and down as required
Competency development not part of role.	Assists development of competencies through modelling and task-sharing.
Problems resulting from gaps in competence likely to be viewed as the person's failure, and used to justify indefinite extension of substitute competencies.	Gaps in competence are noticed before problems occur. Response is short-term compensating rise in input, and increased skill-sharing effort.
Requires only a coarse 'alarm bell' feedback arrangement.	Requires reliable and efficient feedback.
Direct contact can be limited to level required for delivery of care	Requires high levels of direct contact for monitoring and competency development.

One of the interesting points from this table is that a *support* relationship requires a high level of contact between A and B. Without it, the level of support can't be adjusted quickly in response to the person's changing need. In most situations, the contact will also be essential in order to increase A's competencies, whether through modelling, guidance, or more formal teaching. Close contact and good feedback do not in themselves guarantee a *support* relationship; but without them the relationship is likely to be one of *care*.

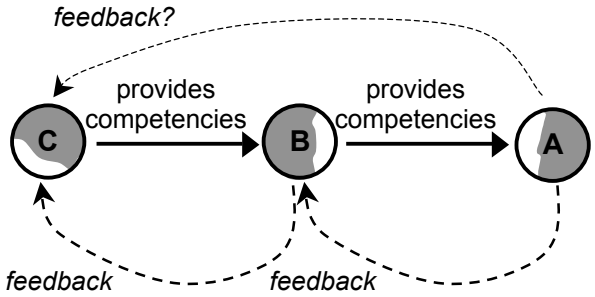
The triangle of support

The situation becomes much more interesting when we add in the third person, C. The need for C arises when A and B, even in combination, don't have the competencies required by the situation. C brings the missing competencies.

There are many ways in which C could provide their skills. They might offer advice to B over the phone, or visit occasionally to meet both A and B; or become B's full-time colleague. The arrangement is likely, however, to tend toward one of two forms. In one form, C works directly with A, alongside B. In the other, there's a chain of support: C supports B, B supports A. These two types are shown in the diagram below.



The support triangle



The support chain

In the triangle arrangement, C gets information directly about A's changing needs, abilities, and wishes, and this makes it possible for C to respond as required. This feedback loop is not automatically present in the chain.

In the chain arrangement there is a support relationship between B and C. The chain could be even longer, with a D and an E, each delivering (for example) increasingly specialist advice. We also think the model can be extended to cover not only relationships between individuals, but also between services and agencies.

It's reasonable to suppose that the B-C relationship can also be one of *care* or *support*. In that case we can go back to the table that contrasted the two kinds of relationship, and see how it fits the relationship between specialist workers or agencies, and mainstream (or less specialised) services. It turns out, as shown in the table below, that it fits very easily.

The relationship between specialist agency and generic agency	
'Care'	***'Support'***
Presumes that other agencies cannot acquire the competencies to include people with special needs, and that the community will not learn to include people with learning disabilities	Believes in the potential ability of other agencies, and the community in general, to increase their capacity to include people with learning disabilities.
Aims to sustain a discrete set of services, on which other agencies will be dependent	Aims to *augment* the competencies of other agencies, where necessary.
Hand-over of control is a condition of access to services.	Input delivered as and where required, allowing others to continue their primary support role.
Judges the competence level of other agencies, then delivers fixed level of specialist skills.	Works cooperatively with other agencies, adjusting input up and down as required
Competency development not part of role.	Capacity-building work is a high priority.
Problems resulting from gaps in competence likely to be viewed as failure by generic services (or the community in general), and used to justify indefinite extension of specialist service input	Gaps in competence are noticed before problems occur. Response is short-term compensating rise in input, and increased skill-sharing effort.
Requires only a coarse 'alarm bell' feedback arrangement.	Requires reliable and efficient feedback.
Direct contact can be limited to the level required for delivery of services.	Requires high levels of direct contact for monitoring and competency development.

Earlier it was suggested that a *support* relationship demanded a high level of contact. This presents a challenge for chain ABC relationships, as there may be little or no direct contact between A and C. C is reliant on B to provide information about A's changing needs. Moreover, C's involvement may be experienced by A as very disempowering. It's easy to think of 'everyday life' examples of this: the person on the telephone helpline who will do no more than pass on the decision made by some unknown service manager; or being treated in hospital but never getting a chance to speak to the consultant.

Using the triangle of support

We've found the model very useful in thinking about different working arrangements between specialist and mainstream services, and in assessing whether a specialist service is working in a way that will increase social inclusion.

Specialist agencies that are operating in the paradigm of *care* will not help mainstream services to learn how to include people with learning disabilities or mental health needs. Their belief in the inability of mainstream services is likely to be a self-fulfilling prophecy. There's a paragraph (6.3) in *Valuing People* that describes this happening:

> *Because mainstream health services have been slow in developing the capacity and skills to meet the needs of people with learning disabilities, some NHS specialist learning disability services have sought to provide all encompassing services on their own. As a result the wider NHS has failed to consider the needs*

of people with learning disabilities. This is the most important issue which the NHS needs to address for people with learning disabilities.

Changing the culture of specialist services, to match the characteristics of *support* relationships, is a vital first step to developing an organisation that will progress social inclusion. The *care/support* table could also be translated into a set of indicators to measure how well the change is progressing. But there are also other practical implications of the triangle of support:

- Is the specialist agency extending its work in mainstream services (such as primary health care) and more generic services (such as social care settings) using working arrangements that enable skill-sharing between specialists and non-specialists?

- Do the working relationships between the specialist and mainstream providers have the flexibility for support to be added or reduced in response to the changing needs of the mainstream provider?

- Is the specialist support to mainstream providers offered on terms (whether stated in contracts, or otherwise implied) that do not undermine the lead role of the mainstream agency? (Or is the message, in effect, *"If you want us to help, you'll have to let us take charge"*?)

- How effective is the feedback loop between specialist and mainstream providers, to enable the specialists to know how and when to change their input?

- Is there a strong feedback loop between the specialist provider and the people who are the ultimate, though indirect, recipients of their services? Feedback may need to include direct contact between specialists and service recipients, and also arrangements that support genuine participation and consultation.

- Is the relationship between the specialist agency, and organisations that have strategic responsibility for service development (commissioners, for example), characterised by the qualities of the support relationship?

Perhaps the key lies in the somewhat old-fashioned notion of humility. The participants - mainstream services, specialists, the people who require support, and the wider community - all have gifts to bring to the task of achieving an inclusive society. They all, equally, have their limitations. Accepting that truth will surely make the best starting point for partnerships that have the hallmarks of a true *support* relationship.

The National Development Team is an independent, not-for-profit organisation that works to improve policy and services for people with learning disabilities, or mental health needs, and for other disadvantaged groups. The NDT's services include consultancy, training, and policy development. For further information about the work and services of the NDT, please contact the national office at 01473 836440, email office@ndt.org.uk, or visit our Web site at www.ndt.org.uk