What Makes Empowerment So Difficult?

Peter Bates - Tizard Centre

Abstract

Speech is used as both a concrete example of empowerment and as a metaphor for a lifestyle of choice, assertiveness, and relationship. This essay looks at some of the ways in which a career in the psychiatric services can be a journey into silence. After a discussion on the nature of empowerment, the area of group participation by service users in the planning process is selected to illustrate ways in which the voice of the service user can be heard more closely.

Mental Health and Inequality

Difficulties and disabilities tend to cluster below the poverty line so that people who are have one disadvantage tend to fall victim to others also. Mental distress can be seen as a reaction to oppressive and limiting circumstances in which individuals have little room for manoeuvre and few supports to protect them from life's crises. The circumstances of women serve as an example of this principle. In employment, women earn less than men (Social Trends 1992, Table 5.6) and are less likely than men to be promoted (Goss and Brown 1991). At home, chores are unevenly shared between partners (Szalai, cited in McCloughry 1992, p. 242) and over a third of married women suffer violence or the threat of violence from their husbands (Miles, cited in McCloughry 1992, p. 57). Out of the house, women are more likely to become victims of crime (Jones, MaClean and Young 1986, p. 84).

Studies of the demography of mental illness confirm the links between social disadvantage and mental distress. Placing the counter at any point in the process (days off work, GP visits, admissions to hospital, or compulsory detention) always reveals the same results (The Mental Health Foundation 1990) i.e. rich white males are less at risk than people from ethnic minorities, poor people and women. It would appear that the structures and processes of late twentieth century British society which deny certain groups a job, status, recognition and respect also precipitate crises which are labelled as mental illness. Employing the medical model of causation then focuses attention and treatment upon the individual casualty

This means that people groups which are devalued in society find themselves with fewer options and opportunities, socialised into silence as a way of life. Addressing these problems by anti-oppressive practice means more than positive action on equal opportunities policies in employment and service delivery (although these are essential too). Those who have been socialised into silence need cash as well as counselling; decent housing as well as high quality care; jobs as well as therapy.

Admission to Hospital

Admission procedures in psychiatric hospital strip confidence and replace it with a sense of powerlessness (Goffman 1961,p.24-47). During the assessment which accompanies compulsory admission under the terms of the Mental Health Act 1983 the psychiatrist, social worker or nearest relative consider whether the client is a danger to themselves or others. Patients

detained on these terms must be closely supervised and protected - a practice which militates against what Perske calls the 'dignity of risk' (cited in Wolfensberger 1972, pp 194-206). Professionals invest a part of their own success in the safety of the patient, so those very professionals are likely to deny both the client and themselves the right to fail. Thus the patients' orbit of choice and opportunity shrinks.

Reducing the number of psychiatric admissions will help with these problems. The ordinary life principle, whereby benevolent services must justify each and every removal of a civil liberty, is much easier to apply in community based services since the elements of care are separately delivered and each one must be individually justified. The work of the Institute of Risk Management has not yet been extensively applied to psychiatric services, but the adoption of an adequate risk policy would do much to release junior staff from operating in a defensive and over protective manner out of fear of being scapegoated by their service manager.

Staying in Hospital

Barton (1959, p. 2) described institutional neurosis as a "disease characterised by apathy, lack of initiative, loss of interest ." Goffman's work, published in 1961, showed clearly how the features of the 'total institution' such as segregation of residents from both staff and the outside world, confusion of work, leisure and social roles, and block treatment, act to reinforce and maintain the acquiescence of individuals subject to this controlling lifestyle. The most personal of daily routines about where to eat, what to wear, whether to wash and when to sleep, are changed and perhaps directed by others, again reinforcing the loss of autonomy. As these processes were exposed and recognised as destructive, the plans to close the large institutions gained momentum.

Over the last decade, the gradual adoption of the normalisation principle in the statutory psychiatric services (Emerson in Brown and Smith (eds) 1992 Ch.l) has encouraged staff to hand back responsibility and decision-making to service users. Individuals have more choices over activities of daily living, and ward meetings take place where patients can express their views on matters which affect the community.

More radically, Patient' s Councils have been established in some hospitals (Gell in Winn (ed) 1990, Ch.6) where hospital residents meet with a facilitator in the absence of staff to talk over matters of common concern. In a separate meeting, service users can meet with the management to comment on present and proposed services. Newcomers witness the positive example of hospital patients speaking out, thus demonstrating that the institution does not have to utterly silence its residents.

Treatment

Many people admitted to psychiatric hospital are bewildered and frightened by their thoughts and feelings, sensing that they are out of control, helpless to manage their internal or external world. The very mechanics of speech can be interrupted by medication side-effects such as a dry mouth and tardive dyskinesia, while primary symptoms a such as thought blocking or emotional lability can leave the patient with a feeling that nobody understands their current experiences. Submission to electro-convulsive therapy, mind or mood-altering medication can further reinforce the sense of powerlessness and affect social skills. Communication skills are almost

universally damaged by a stay in psychiatric hospital. The absence of speech therapists on the payroll of the multidisciplinary team is notable.

A component of treatment which might have been expected to support interpersonal skills is the 'therapeutic relationship' with staff, but this is fraught with difficulties also. A power differential between staff and service user is created and maintained by a barrage of signs and symbols, such as name badges, offices, telephone interruptions (always for staff) and different time structures (staff are almost obsessively busy, too busy to talk). These symbols of power combine with the illusion that the therapist 'has the answers' and so convert mutuality into professional distance and inequality. Underlying these practices are stereotypical assumptions that service users will exploit the relationship if given the chance, but clients are also at risk - of sexual abuse (Rutter, cited in McCloughry 1990, p. 75, and Davidson in Howell and Bayes (eds) 1981, p.147) and theft (Shearer 1982) from their therapists, so there are grounds for doubt and suspicion on both sides.

Long stay wards do not promote informal friendships and community meetings between residents have the potential to pattern insincere relationships rather than warmth or genuineness. The accusation that such community meetings are superficial may well be justified, especially if the agenda is composed of items such as the washing up rota or the preferred TV channel, while weightier matters such as staff recruitment, budgetary allocations or the available activities are predetermined by the staff.

Discharge

Despite the Government's promises of choice and opportunity for all (Caring For People Para 1.8), and more specifically, a mixed economy of care in the community (NHS and Community Care Act), many discharging patients find few opportunities to exercise choice. The Care Programme Approach laid a duty on Health Authorities from April 1992 to only discharge patients where there was a clear and agreed plan of aftercare. Unfortunately, there was no indication of what constituted an adequate standard of care, so discharges to bed and breakfast accommodation, to night shelters, or to unfurnished tenancies have continued. Any sense of order or internal locus of control (Warner in Ramon (ed) 1991, p.125) which was built up during the hospital stay is quickly dismantled in a discharge of this kind.

Assuming clients survive the turmoil of discharge, then long-term unemployment, lack of social networks or meaningful daytime activity, poor housing and poverty conspire to rob them of the self-esteem essential to speaking out. Leaving the institutional building behind does not guarantee the ending of institutional practices and so a network of community supports may well re-create a institution under many roofs instead of one. In conclusion, the journey through the psychiatric services may be a journey into silence.

So What is Empowerment?

The foregoing summary suggests that empowerment is a broad-based concept linking the internal and external world of service users. The target of empowerment is to achieve an internal equilibrium in which the person recognises their intrinsic value and opportunity to act, as well as an external environment which reflects dignity and provides a high quality of life.

Empowerment in mental health services is fed by three major streams (Brandon 1987 offers a seven-fold analysis). The most specific is normalisation theory or social role valorisation which supports the emphasis upon the external world and interpersonal relationships. Nirje (in Kugel, R. and Wolfensberger, W. (eds) 1969, pp.255-87) defined normalisation to include such external factors as normal-sized living units, the possibility of decently paid work and participation in decision making. The significance of material and environmental living conditions must not be ignored by any service which claims to take even a part of its agenda from the expressed wishes of clients. Normalisation is less helpful in defining the process for achieving an internal locus of control, rather taking it for granted that a suitable environment and egalitarian social relationships will be reflected positively in the person's inner world. On this basis no-one would be miserable if transported to paradise.

The second source feeding the empowerment stream is the user movement. Growing out of the anti-psychiatry thinking of the 1960 ((Laing 1959, Szaaz) and strengthened by hopeful stories of user power influencing service design in Scandinavia and the USA, a number of user-managed groups have gained strength during the 1980's and early 90's. These groups vary from the Patient's Councils mentioned above, through to groups such as the Hearing Voices Network which provide an alternative perspective on psychotic experience.

The third stream is provided by various political models of democracy. Lessons have been drawn from widely diverse ideologies such as consumerism, the black and women's movement, workers co-operatives, and consensus decision-making. All of these perspectives simplify the voice of the service user and focus attention on themes of power sharing and participation. Unfortunately, there is a credibility gap between theory and practice since society offers few models of effective consultation and participation. Only some people turn out to vote (Social Trends 1992 Table 11.14), political campaigning is restricted to a vociferous minority, and many citizens believe participation is futile. Furthermore, inherent conflicts surface when attempting to operationalise participation. For example, a group of service users may share in selecting a property for their home in the community, but consultation with the neighbours indicates that the majority do not want the house next door. Where is democracy here?

These three streams flow together to strengthen the empowerment movement and give it face validity in most boardrooms around the country. Because empowerment is a holistic concept and effects many areas of life it is not immediately clear where one might begin to assist the empowerment process. For example, Welfare Rights Officers who work to maximise service users' benefit income are massively increasing their clients' choice and opportunity to participate in society. Despite this consideration, many people working in the empower field have chosen the design and delivery of mental health services as a starting point for their intervention and have decided to use groups as a method to achieve that end. This fits in with the requirement laid upon Social Services Departments to engage in public consultation when drawing up community care plans (Disabled Persons Act 1986 and NHS and Community Care Act 1990). If services become less silencing, then perhaps service users will retain more of a voice during their career in the psychiatric system and be enabled to share in decision-making both in and out of the service. But before we turn to look at the use of user groups in service planning, it is important to identify a number of blockages which might interfere with achieving this laudable goal.

Blockages - The Ideological Environment

The mystique of professionalism has created a whole subculture in which the spoken language is management speak, the written language is dominated by acronyms, the pace is hectic, and all interactions take place in something called a 'meeting' which has its own specialist rules of conduct. These rules bias the process away from women (Lockheed and Hall found that men tend to be more verbally active and initiate more task-oriented behaviours than women in mixed-sex groups. Cited in Ragins and Sundstrum 1989), from non-readers, in fact from all those people who have not been socialised into this culture.

A further aspect of the technocracy that has particular significance in psychiatric services is the fact that people who make up the decision making elite do double duty as therapists. Part of the process of socialisation that takes place when people become patients is that they take on the notion that "doctor knows best", and in psychiatry, "doctor thinks best". Empowerment means that the patient recovers their belief that they think best for themselves.

As each social system Contains a limited amount of power, then increasing the share for service users means reducing the share for staff. Arnstein offers a typology which shows eight rungs in a ladder towards citizen participation. The first five are classified as "Nonparticipation" and "Degrees of Tokenism" in which the illusion of participation is created. As Arnstein crisply comments:

"Participation without redistribution of power is an empty and frustrating process for the powerless."

So the mystique of professionalism, the status of professionals and their self-interest conspire to maintain the status quo.

Blockages - Management Systems

Peters criticises large organisations for 'siloing' - cresting chimneys where messages travel up and down through many levels before the practitioner is released to act. This organisational inertia can be exacerbated by defensive management where the worst-case scenario delimits day to day policy, risk assessment and scapegoating is the currency of the human resources strategy. When power is exerted from the manager's office rather than the resident's lounge, service users feel like powerless guests in someone else's accommodation, rather than part owners. Normalisation theory has addressed some of the deficits of institutions, but, as Ramon (1991, p.9) comments

> "To date the issue of how to dismantle an institution is yet to be addressed by Social Role Valorisation protagonists. This serious Omission may be linked to the strong emphasis on individuals rather than on the collective, to not taking organisational issues seriously, and the disinterest in the issue of social control."

The net effect of these arrangements is that junior staff (who represent the bulk of staff/client encounters) feel powerless in the organisation. Participative decision making can only happen where there is a clear arena of control for power holders to share with colleagues and service users.

Blockages - The Lack of Hopeful Stories

Given the above roadblocks on the journey towards user empowerment, it is difficult to find a sympathetic environment where good practice might develop. The inertia is so great that most teams can only tackle one or two areas at a time and must leave the rest to others. Good storytelling in the press and at conferences serves to raise optimism about what is possible and to chart a pathway forward. The user movement is growing in strength and influence, but it is still the case that empowering initiatives rely heavily upon a few individuals, that qualifying and post-qualifying training for professionals feature the subjects of normalisation and empowerment as isolated seminars rather than a theme pervading all their work, and liaison with areas such as personnel, finance, audit, health and safety and insurance has not generally begun to create alternative strategies.

Empowerment is about uncovering and tackling the unmet needs in the daily life of individual service users. It is also about decision making structures in society and methods of affecting these processes. The essay closes by reviewing the processes whereby users can be involved in groups where services are designed. Shared decision-making raises a number of key practice issues which serve to illustrate some possible ways forward.

Information Sharing

The first element is that of information dissemination. Open information systems are difficult to achieve in places where the prevailing climate is one of secrecy or where clients are viewed as untrustworthy or incapable. Most of us, when faced with a new situation, prefer to sit quietly and absorb information at our own pace before venturing to comment. Similarly, even the most disabled people have a right to be exposed to an environment of information, to which they may or may not wish to give a public response.

A second reason which is sometimes given for withholding information is language. Many documents are complex in style, contain acronyms and jargon, and are only available in English. The task is one of translation. Pictures and symbols can augment some headings (Community Living Development Team 1991), plain speech can replace jargonised shorthand, apt illustrations from everyday life can bring dilemmas to life, and documents can be taped. Translation is skilled, time consuming work and perhaps some messages are not susceptible to this process, but the deficit may well be in the commitment and skill of the translator rather than the complexity of the message.

A third reason which is sometimes given for withholding information is the nature of the service. Congregated daytime or residential services are expected to keep people informed, but dispersed services cannot achieve this. The problem here is a confusion of the medium with the message. For example, a team of Care Managers might visit a group of clients in their own homes who never meet one another. If a vacancy arises in the team, then every client is a stakeholder in that service and has a right to be informed and involved. The staff team could meet and agree a message that they wish to communicate to every client and then take it out with them on their visits. Responses could then be collated on their return. This "Town Crier" model of information sharing is often more appropriate in congregated services also and messages will be communicated far more effectively by workers walking through the service and re-translating their message for every client they meet.

Meeting Structures

Traditional committee procedures are inaccessible to many people and it is incumbent upon workers to discover alternative methods which are more effective. For example, providing tea and frequent breaks for smokers can make all the difference. Some people cannot concentrate for long periods or move from topic to topic, so short, frequent meetings with very short agendas are more appropriate. Agreements about acceptable behaviour in the group can help, as long as the group does not begin with a list of intimidating rules. In particular, whether members can share details of their personal lives, or whether the topic must be "business" from the agenda will strongly affect the sense of engaging as whole people or restricting conversation to the task. Secret ballots might avoid the fear of members being dominated by one person in the group. Putting options in a hat or negotiating towards a consensus may be more appropriate than the rule of the majority. Practical matters such as who signs for financial transactions, the clarity of financial records and key holding for the building where the meeting takes place will have a profound influence upon the empowerment in the group.

Training

The foregoing implies that empowerment is a gift bestowed by enlightened staff upon service users. Freire declares the exact opposite and says that "freedom is acquired by conquest, not by gift" (1972, p.24), and adds a warning about enlightened staff.

"certain members of the oppressor class join the oppressed in their struggle for liberation...they almost always bring with them the marks of their origin... a lack of confidence in the people's ability to think, to want and to know...they believe that they must be the executor of the transformation. They talk about the people, but they do not trust them; and trusting the people is the indispensable precondition for revolutionary change." (1972, p.36)

Consultancy and training courses are available where users train one another to survive committees, to speak to "top people" (Advocacy in Action), to be more assertive, to manage their own projects (Clarke), and initiatives of this kind have received well deserved commendation. Only where user-led initiatives meet up with the reformed hierarchy on a middle ground where both are learning to share, do creative new shapes begin to form and influence the whole climate of service delivery.

References

Advocacy in Action, 32 Park Row, Nottingham.

Arnstein, S. **"A Ladder of Citizen Participation"** in Journal of the American Institute of Planners July 1969.

Barton, R., (1959) **Institutional Neurosis** Bristol: John E. Wright.

Brandon, A., and Brandon, D., (1987) **Consumers as Colleagues** London: MIND.

Brown, H. and Smith, H. (eds) (1992) Normalisation: A Reader for the Nineties London: Routledge.

Clarke, S and Hawker, C. **"User Management in Care Organisations"** - forthcoming research report from the Centre for Applied Social Studies, University College of Swansea.

Community Living Development Team **"Using Pictorial Methods to Enable People to**

Communicate More Effectively" in Information Exchange on Self Advocacy and User Participation No. I Nov. 1991. London: The King's Fund Centre.

Friere P. (1972) **Pedagogy of the Oppressed** Harmondsworth:

Goffman, E. (1961) **Asylums** London: Pelican.

Goss, S. and Brown, U. (1991) **Equal Opportunities *for* Women in the NHS** NHS Management Executive.

HC(90)23/LASSL(90)11 sets out the responsibilities under the Care Programme Approach.

Howell, E. and Bayes, M. (eds) (1981) **Women and Mental Health** New York: Basic Books.

HMSO (1986) The Disabled Persons (Services, Consultation and Representation) Act

HMSO (1989a) **Caring for People** HMSO CM 849.

HMSO (1990) The NHS and Community Care Act. HMSO.

Institute of Risk Management, Albion House, 87-89 Aldgate Right Street, London EC3N

Jones, T., MaClean, B., Young, J. (1986) **The Islington Crime Survey** Aldershot: Gower.

Kugel, a. and Wolfensberger, W. (eds) (1969) **Changing Patterns in Residential Services for the Mentally Retarded** Washington: President's Committee on Mental Retardation.

Laing, R.D. (1959) **The Divided Self** London: Penguin.

McCloughry, R (1992) **Men and Masculinity** London: Hodder and Stoughton.

Mental Health Act 1983, HMSO.

Mental Health Foundation (1990) **Mental Illness - The Fundamental Facts** London: The Mental Health Foundation.

National Hearing Voices Network, MCVS, Fourways House, 57 Hilton Street, Piccadilly, Manchester MI 2EJ.

Peters, T. (1987) **Thriving on Chaos** London: Macmillan.

Ragins, B.R. and Sundstrom, E **"Gender and Power in Organisations- A Longitudinal Perspective** Psychological Bulletin 1989 Vol 105. No 1,pp51-88.

Ramon, S. (ed) 1991. **Beyond Community Care: Normalisation And Integration Work** Basingstoke and London: Macmillan.

Shearer, A. (1982) **Living Independently** London: King's Fund.

Social Trends (1992) 22 HMSO

Szaaz, T. The Myth of Mental Illness

Winn, E. (ed) (1990) **Power to the People: The Key to Responsive Services in Health and Social Care** London: King's Fund.

Wolfensberger, W. (1972) **The Principle of Normalisation in Human Services** Toronto National Institute of Mental Retardation.