# Clinical leadership for social inclusion

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## Abstract

Social inclusion is a goal of all users of mental health services. But to be achieved, it must also become an explicit goal for all clinicians. Traditional clinical service systems may inadvertently hinder rather than promote social inclusion. An understanding of the components of service delivery that contribute to this can inform the development of more socially inclusive practices within mental health services. However, strong clinical leadership is also required to achieve the change necessary for clinicians to facilitate social inclusion for mental health service users.

## Key words

social inclusion; mental health services; service users; service systems; clinical leadership

## Introduction

A socially inclusive society is defined as one where all people feel valued, their differences are respected, and their basic needs are met so that they can live in dignity (Cappo, 2002). To be socially included, all members of society must be given the opportunity to secure a job, access services, connect with family, friends, work, personal interests and local community, deal with personal crisis and have their voices heard (Australian Government, 2008).

In contrast, social exclusion is the process of being shut out from the social, economic, political and cultural systems that contribute to the integration of a person into the community (Cappo, 2002). It has been described as the existence of barriers that make it difficult or impossible for people to fully participate in society or obtain a decent standard of living (Social Exclusion Unit, 2003).

People with mental illness have long desired social inclusion but experienced social exclusion. This paper explores the way in which clinical service systems may be contributing to social exclusion and challenges clinical leaders to directly address factors that can promote social inclusion.

## Do clinicians support social inclusion?

With rare exception, mental health clinicians would support the goal of social inclusion for service users. Yet, many would be surprised to learn that they are sometimes perceived as being more of a hindrance to recovery and social inclusion than a facilitator of positive change. There are many factors that potentially contribute to this negative perception and examination of some of these may help to illuminate the role that clinical leaders may play in furthering the quest for the

achievement of social inclusion for all persons with mental illness.

## Risk aversion

Service systems driven by risk management are conservative by their very nature, and may unwittingly impede opportunities for new ways of responding to consumer and community needs. Contemporary health service systems have vigorously embraced risk management practices, and are thus no exception. Political and societal expectations of the health system and health practitioners often work to reinforce this approach. We frequently see public blaming by sensationalist and indignant media as the response to adverse outcomes, rather than tolerance to the perturbations of life that others without mental illness are allowed. However, health systems may also fuel escalations in the media culture of complaint through a lack of transparency, open disclosure and public consultation.

## Paternalism and power

Paradigms shaped by well-intentioned paternalism towards the mentally ill are still frequently the norm within clinical mental health settings, as well as in the community. Consumers of mental health services experience paternalism as restrictive and constraining. Yet, if a mirror was to be held up to clinical services, the power differential inherent in paternalism would all too often be reflected in the clinical hierarchy seen within services. It is sustained by professional differences and rivalries that have little to do with the well-being of consumers with mental illness and more to do with maintaining professional turf. Delivering truly consumer-centred services with a focus on social inclusion means reappraising some long-held professional traditions and conceding turf.

## Culture

In more recent times, mental health services have begun to understand the importance of cultural safety to the delivery of quality services, but have not always demonstrated awareness of its importance to the achievement of social inclusion. The National Aboriginal Health Organization of Canada (2008) states:

> 'Cultural safety within an indigenous context means that the educator/practitioner/ professional, whether indigenous or not, can communicate competently with a patient in that patient's social, political, linguistic, economic, and spiritual realm. Cultural safety requires that health care providers be respectful of nationality, culture, age, sex, political and religious beliefs, and sexual orientation. Cultural safety involves recognising the health care provider as bringing his or her own culture and attitudes to the relationship.'

This definition confirms the importance of cultural safety for social inclusion to be achieved. However, it also highlights that clinicians must demonstrate not only an awareness of the culture of their consumers, but also a self-awareness of their own culture, including where their profession fits within the power gradient, to be culturally safe.

## Evidence-based care

The modern day mantra of evidence-based care, and the predominance of neuroscience over psychosocial approaches in contemporary mental health services can also impede delivery of the holistic care necessary to achieve social inclusion. Evidence-based care is perceived to be scientific and quantitative. It is often limited to addressing the needs of the individual alone.

Where an evidence base exists, it should of course be followed. However, the absence of a sturdy evidence base should not equate to an absence of attention to other facets of care. The past two decades have seen unprecedented investment in biological research within psychiatry, resulting in a wealth of new medications and biological approaches to the management of mental illnesses. Yet, the life of an individual with a mental illness is not so neatly divided into biological and psychosocial components. Mental illness, with its attendant symptoms and signs, is but one facet of the whole person. For those who experience mental illness, treatment of their signs and symptoms is often not their most prominent need, yet that is the skill base of the clinicians who seek to assist them, and hence, their primary area of focus. Its primacy in treatment is often reaffirmed by the latest evidence. Support and recovery-related tasks are frequently allocated to non-clinicians, and the evidence base to guide their interventions is often less strong and sometimes non-

existent. Hence, we see value being attributed, and interventions prioritised, on the basis of the skills of the clinical practitioner or the evidence base alone, rather than the needs voiced by the consumer.

Yet, neurosciences-based evidence is not the only determinant of good outcomes. Many studies have demonstrated a better long-term outcome for schizophrenia in developing countries, particularly in rural regions (World Health Organization 1973; 1979; Leff et al, 1992). The reasons for this phenomenon are unclear but almost certainly do not rest in evidence-based medicine. More likely explanations include: greater inclusion or retained social integration in the community in developing countries, so that the person maintains a role or status in the society; involvement in traditional healing rituals, reaffirming communal inclusion and solidarity; availability of a valued work role that can be adapted to a lower level of function; and availability of an extended kinship or communal network, so that family tension and burden are diffused (Rosen, 2006). Clinicians must take account of the growing evidence base over the last 30 years for the positive influence of traditional factors on outcomes in severe mental illness related to social inclusion, such as non-exclusion, maintaining a productive role, and extended kinship network.

## Experience-informed care

Approaches that seek to recognise the value of user experience are growing in many professional fields such as architecture, technology and web design (Burghardt & Hacker, 2004). While health systems are increasingly persuaded about the value of encouraging user participation in service planning, delivery and evaluation, few have afforded this equal value when compared to evidence-based medicine. However, this experiential evidence is recognised as particularly important in achieving cultural safety for indigenous people (where knowledge, customs and beliefs must be understood to inform the current context of any individual and where the focus must consider the collective, such as family and community, rather than just the individual) and must now be accepted also by all mental health services. This means that clinicians must give

greater weight to a consumer's perceptions and experience of care when collaboratively planning treatment, and ultimately must find a way to balance scientific evidence-based medicine and experience-informed care for the delivery of mental health services that maximally promote social inclusion.

## Service system configuration

Mental health service system configurations may also contribute to socially exclusive practices. Splitting tasks into clinical and non-clinical is usually necessary to maximise efficiency in cash-strapped and workforce-challenged mental health services. Offering choice to the mental health consumer may overwhelm the capacity of the system where resources may not afford multiple choices in care options. So-called mental health services for the most part are really mental illness services, have limited resources and simply cannot do everything for everyone. As a result, there are increasing calls to invest in the non-government sector, which is staffed by a broader workforce base and is perceived to be more economical and less stigmatising. Partly because of the absence of a focus on signs and symptoms, this sector appears to be experienced as more able to meet the needs of the whole person. But parallel or competing systems between clinical and non-clinical services must not be allowed to operate; public mental health services must not regress to become solely clinical symptom treatment systems, without retaining a strong rehabilitation and recovery focus. There must be collaboration and co-operation between the health and social care sectors, and service systems must be set up in such a way as to guarantee this; or else it is only likely to increase, rather than decrease, the experience of social exclusion by users of public sector mental health services.

## Clinical leadership and social inclusion

Clinical leaders have an important role to play in overcoming the barriers outlined above. Strong clinical leadership is a key to success in facilitating recovery and enhancing social inclusion for those in our community who experience mental illness. Without it, mental health services will continue to deliver services in line with traditional roles and prevailing risk

aversive management paradigms, and barriers to change will continue. Change will not deliver itself.

Clinical leaders must be passionate and persistent, and must advocate for the changes necessary to achieve social inclusion, commencing with policy-makers, health service funders and commissioners. They must dispatch paternalism to the annals of history, and embed recovery and social inclusion as explicit outcomes of service delivery. In doing so, they must shape the expectations of all service providers and the community. They must also educate the community that these goals impose active requirements on the population at large, and a range of social care agencies in particular, to embrace those with mental illness, demonstrate tolerance and extend to them the opportunities afforded to those without mental illness. As respected professionals with expertise in mental health, clinical leaders can impact positively and persuasively at this broader level. However, the converse also applies, for acceptance of new ways will be slower without explicit endorsement from clinical leaders that those with mental illness can participate safely and effectively as full citizens in the community and should be afforded this right.

Likewise, the task of enhancing understanding and achieving greater community tolerance will not be readily achieved if clinicians do not identify with it. It is probably safe to say that presently, not all do. Clinical leaders must begin, therefore, by challenging themselves and all clinicians within their service to review their values and their understanding of the paradigm of recovery, and of what is required to experience equity of opportunity and achieve equity of outcomes for their service users. They must be courageous enough to challenge paternalism and confront nihilism, whether it is based on pessimism or fear, and to champion new ways of thinking and delivering services that promote choice and enhance, rather than impede, social inclusion.

Clinical leaders must also be determined and resilient, where necessary, going back to basics to build new structures and processes within their services that affirm the message and maintain the focus on social inclusion. They must emphasise the importance of the

art of listening and the necessity of creating a relationship with the mental health service user to achieve experience-informed care. This will give context to the consumer's reported signs and symptoms, as well as highlighting the directions where intervention by other agencies may be required. It goes without saying that clinical leaders must foster and promote close collaboration with those other agencies, and be prepared to be innovative and willing to take risks when opportunities for new ways of working present themselves.

Innovation, coupled with evaluation, can help to build the evidence base in areas where evidence may currently be scant, and clinical leaders have a responsibility to contribute to this. Health services research is a growing field of interest, and can be effectively contributed to by clinical leaders 'on the job', when quality measurement strategies tracking structure, process and outcome measures across domains relevant to social inclusion are embedded in routine service delivery. Contemporaneous feedback to staff on the information generated by such quality measures is essential to maintain meaningful data collection. It also serves to further enhance staff knowledge and understanding of social inclusion as a key goal of treatment. Recording tangible change across 'real-life' domains such as employment, housing, social networks and civic engagement can be highly affirming for service users and staff alike.

Celebrating successes achieved in relation to social inclusion and communicating key messages both within and external to the service must also be part of the role of the clinical leader for, as the saying goes, 'nothing breeds success like success'. Active marketing and communication must, therefore, be part of the contemporary mental health service framework.

## Conclusion

In summary, clinical leaders have a critical role to play in facilitating social inclusion for those with mental illness. Without their contribution, the case for change is unlikely to gain sufficient momentum to overcome the powerful clinical paradigm that those with lived experience of mental illness report adds to their stigma, constrains their recovery and impedes their full participation in the community.

## Implications for practice

- Clinicians are often perceived as hindering rather than facilitating social inclusion, yet many would be unaware of this.
- Risk-aversive management systems may impede the new and innovative ways of service delivery required to achieve social inclusion.
- Consumer-centred services require a reappraisal of the historically-derived power-driven paradigms underpinning professional traditions and paternalism.
- The concept of cultural safety informs clinicians seeking to achieve social inclusion, particularly the need to be aware of their own culture.
- Experience-informed care must be given equal value as evidence-based medicine.
- Service system configuration can exacerbate social exclusion and must be carefully considered.
- Recovery and social inclusion should be embedded as explicit outcomes of mental health service delivery.
- Strong clinical leadership is necessary if mental health services are to change and promote greater social inclusion for people with mental illness.
- Roles for clinical leaders include advocacy, community education, promoting values, challenging paternalism, confronting nihilism, fostering collaboration, celebrating success and communicating key messages.
- Quality measurement strategies that track structure, process and outcome measures across domains relevant to social inclusion should be embedded in routine service delivery.

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## Peggy Brown

Dr Peggy Brown graduated from University of Queensland in 1983 with honours and completed her training in psychiatry in 1990. In 1991, she was awarded the Maddison Medal by the Royal Australian and New Zealand College of Psychiatrists for meritorious performance during her psychiatry training. She has worked in a range of clinical positions in

Queensland and the United Kingdom, and held senior administrative positions, including the position of Director of Mental Health, in both Queensland and the Australian Capital Territory. She has been actively involved within the Royal Australian and New Zealand College of Psychiatrists at state, territory and national level, including serving on both the Committee for Training and the Committee for Examinations. In addition, Dr Brown has extensive experience in national mental health policy forums, including the Mental Health Standing Committee. She is currently the Chair of the Safety and Quality Partnership Subcommittee of the Mental Health Standing Committee. In 2000, her achievements were recognised when she was awarded the Queensland Telstra Business Woman of the Year.