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New paradigms from the past: How far can the active citizens of today's health and social care policy really realise empowerment without the welfare approaches of the past?

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Abstract

Social models emphasising active empowerment in policy and service responses to long-term health and social care concerns, are hailed as pivotal by UK policy in the promotion of citizenship rights and effective interventions. These policies treat individual capacity-building, social participation, self management of health, and emphasis on community supports in preference to dependence on services and professional care, as the best route to positive outcomes. Significantly, however, these developments carry echoes of the historical Poor Law assumptions of the normal human being as completely in control of self and environment, seeing vulnerability to the impact of social and biological forces as marginal in human society. This has led policy to view as counterproductive, earlier welfare state arrangements which recognised the damage and suffering implicated in the human impact of these forces and prioritised entry to the 'sick role' and specialist professional and service interventions to alleviate these concerns. How far, however, may today's policies based on such assumptions, really be effective in addressing these health and social care issues? In seeking to explore this question, the paper will, in accord with approaches to policy critique exemplified in current policy studies in the area of frailty, and in emancipatory social theory and service user-led New Social Movements, examine service users' concerns and consider how far the policy assumptions regarding the nature of these concerns can support an adequate response to them. This then forms a basis for paradigm change - considering alternative understandings which can be more responsive to these concerns. The paper will therefore review research evidence pertaining to the concerns of people facing multiple long-term health problems and social exclusion. Exploration of these findings suggests that although these service users seek recognition of their citizenship rights in accord with current policy principles, they also have major concerns with suffering and damage to capacity resulting both from health concerns and the impact of social discrimination, leading them to place enormous value on many aspects of traditional welfare state approaches to vulnerability. Research concerned with the damage implicated in these vulnerability experiences, and evaluations of services responsive to these concerns, can also support the value of such approaches to achieving positive outcomes. This review therefore points to the importance of older welfare policy models in developing empowering health and social care policy, suggesting new approaches which can respond both to citizenship and to the devastating impact of service users' concerns.

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Introduction

An accumulation of research findings demonstrates strong relationships between social adversity, disempowerment and health (White 2003). Income inequalities for example, are statistically associated in many countries with striking differences in the rates of long term physical health conditions (Peckham 2007) and mental health problems (World Health Organisation 2009) : in the UK rates for the former are 44% in the lowest socioeconomic group compared to 26% in the highest (Baggott 2005). These inequalities in income and health are also linked to social exclusion, involving wide-ranging disempowerment including lack of participation in work, social networks and community together with a low sense of influence, and poor access to services and community facilities (Gordon 2000). People with long-term conditions in societies characterised by health inequalities therefore experience what are often termed 'complex needs', involving multiple health and social care concerns, including for example, poverty, isolation, living in poor areas, mental health problems and cognitive impairment, and sometimes substance misuse (Davey 2005, Keene 2001) . The World Health Organisation (WH 2005) has pointed to mental health concerns as a major risk factor for greater disablement and disempowerment, and therefore many of the studies reviewed in this paper relate to mental health.

These connections between health, social adversity and disempowerment are currently recognised internationally and are core to UK Modernisation policy (European Commission 2005, WHO 2005 Department of Health 2006a). In this context, social policy for health and social care in the UK, Europe and beyond converges upon the promotion of social and empowerment approaches as major routes to improved health, wellbeing and independence (Means et al. 2008). These express principles common to different regional approaches to health, including liberal welfare policies in the English-speaking world, corporatist approaches in western Europe, and a high profile for Human Rights, within the wider contexts of the global economic market with its pressures for low taxation - the latter particularly impacting on resources for social care (Means et al. 2008; Fine 2007) These approaches converge upon the prioritisation of social inclusion including citizenship rights, the consumer role, access to employment, mainstream facilities, ordinary social supports and privatisation of welfare over long-term professional interventions and professional-led services (WHO 2002, 2003, Department of Health 2006 Fine 2007, Clarke 2004).

It is a central understanding in the natural sciences (Kuhn 1970), social policy (Markel-Reid and Browne 2006), and service user-led 'New Social Movements' (Barnes & Mercer 2004), that policy and practice is informed by theory - our view of the world will shape our responses to it (Houston 2001). This paper will therefore consider how far the assumptions underpinning current health and social care policies can support adequate

responses to the disempowerment and loss of wellbeing experienced by people with long-term health and social care concerns, and consider alternative understandings which may be more responsive to these concerns.

Policy model of social empowerment and health

How, then, are social and disempowerment influences on health understood in current policy? Empowerment is widely understood as ‘making it possible for people to exercise power and have more control over their own lives’ (Beresford and Croft 1993, p.50, cited in Braye 2000). This can be linked to understandings of frailty resonating with current policy, that ‘while most pathological agents are ubiquitous...social factors are what make people more or less resistant’ (Barrett 2006, p.116), together with understandings of these social factors as individual ‘reserve capacity’ involving ‘the ability to maintain resilience and continue to perform key activities and roles (p.115).

In accord with these understandings, policy promotes ‘active’ aspects of social inclusion to address social adversity and disempowerment and thus maximise recovery and independence outcomes WHO 2002, 2003, 2008; Cabinet Office 2006, Department of Work and Pensions 2006, Department of Health 2006a, 2006b). These ‘active’ forms of social inclusion include social participation, healthy lifestyle and behaviour, employment, a sense of control, and social capital involving individual engagement in formal and informal networks, group membership, shared norms, trust, reciprocity and community and civic engagement (Etzioni 1995). Additionally, although it is recognised that conditions of poverty themselves impact on health and consequently upon independence, healthy behaviour is viewed internationally as a priority means of tackling poverty, social exclusion and dependency or disablement through reducing individual risk of chronic illness, depression and functional decline (WHO 2003, 2005). Similarly, improved parenting skills and knowledge are treated as core in preventing adult health concerns, substance misuse and social exclusion amongst children (Cabinet Office 2006a). In promoting these approaches, policy relies on research findings showing statistical associations between positive health and independence outcomes and the above active forms of social functioning and healthy behaviours (Department of Health 2001, WHO 2005, National Institute for Mental Health in England 2005, Duggan 2002).: ‘Being in work and having social contacts is strongly associated with improved health and wellbeing’ (Social Exclusion Unit 2004, p.4)

These policies have connections to wider influential political theories such as communitarianism (Jordan 2001), which place emphasis upon individual responsibility in the creation of social inclusion (Etzioni, 1995), and contemporary neo-liberal social theories which view society as ‘only comprehensible in terms of the activities of its constitutive individuals’ (King, 1987, p.94, cited Pratt, 2006). Thus policy aims can be summarised in the statement that people with long-term conditions ‘will be given more control over – and will take on greater responsibility for – their own health and wellbeing (Department of Health 2006a, p.13)

What does this involve? In UK health policies, interventions emphasise ‘motivation and instruction’ (Jordan 2004), including cognitive behavioural approaches, in managing symptoms, emotions and accessing work (Department of Health 2005, Department of Health 2007, Department of Work and Pensions 2004). Policy for long-term conditions includes the ‘Expert Patients’ programme, providing people with ‘the skills to better manage symptoms...and empowering techniques such as goal setting and problem-solving which enable them to live more fulfilled lives, independently and at home’ (Department of Health 2006b, p.18). Social care needs are to be met in several countries by accessing work (WHO 2008) and by ‘cash for care’ with which users engage and manage the care they need themselves, ((Department of Health 2006a, Department of Work and Pensions 2006, Fine 2007), and independent, private and voluntary sector organisations with non-professionally qualified staff act as care providers - including in relation to people with such serious concerns as dual diagnosis, domestic violence and childhood sexual abuse (Department of Health 2003, Lowe and Abou-Saleh 2004).

Core to these policies is the aim to extend the concerns of early community care approaches to counter the traditional stigmatisation, segregation and institutionalisation of people with long-term health concerns. These responses were endemic under the Poor Law through its constructions of health and social care problems as moral failings, and later as genetic defects. Subsequently, the post-WWII welfare state emerged, and on the basis of beliefs that needs were universal, (Doyal & Gough 1991), residing in disease rather than in deficits (Oliver and Sapey 2006), legislation was enacted making available a range of free health and welfare benefits, services and professional support informed by knowledge-base, ethics and therapeutic principles. In the view, however, of Community Care policy (Department of Health and Social Security 1989) and of many commentators (Harris 1999, Barnes et al. 2002), the emphasis of the welfare state thus upon professionals and services perpetuated the earlier disempowerment through denying people choice, control and participation in ordinary life. Modernisation policy concurred with these views, seeking ‘A move away from a welfare state that provides passive support to one that provides active support to help the person become independent’ (Blair 2000), and thus in the above policies pursuing aims of citizenship, social inclusion and fulfilment (DoH 2006a).

Tracing the underpinning paradigm of the policy approach

Commentators have linked Modernisation policy approaches to learning theory explanations of health and social care concerns (Jordan 2000). These locate disabling health and social care concerns largely in the individual’s poor coping. Hence for example stress-vulnerability models of mental health which in earlier decades involved recognition of the impact of stressful environments upon biological vulnerability, now focus on the person’s capacity to cope with her or his environment (Taylor and Liberzon 1999) These understandings render the problems as matters individuals can bring under their own control : they are ‘deemed to be excluded by their own design: their own inadequacy to respond appropriately to risks and insecurities – excluded because of mismanagement or desire’ (Kemshall 2002 p.43)

These approaches thus pursue approaches to empowerment with a focus on individual capacity-building as the main route to health and social wellbeing. (Duggan 2002, Clarke 2004) People are therefore expected to experience improved health and social wellbeing through learning healthier responses, taking place by similar means to those involved in the attempt to achieve a better adaptation in any area of life - i.e. through skill-development and exposure to the real-life situations in which they are needed.

It is therefore advocated that 'most illnesses are avoidable' and social wellbeing achievable (Department of Health 2006a) through the above active individual measures. As a consequence, policy emphasises prevention and self-management (WHO 2003, 2005, Department of Health 2005) rather than professional interventions and long-term service provision. Indeed the latter is considered counter-productive through taking the individual away from ordinary life learning opportunities and encouraging dependency, as indicated in the policy that people with health conditions should be at work wherever possible (DoH 2006a). In accord with this, 'many of the professional groups' in a UK study in respect of people with complex needs, were found to 'take account of social (or biological) factors but...interpret and assess problems in behavioural terms' (Keene 2001, p.120).

Can socio-historical precedents tell us more?

Significantly, these expectations are consonant with the value placed upon autonomy by the 'Enlightenment' period in western Europe and the English-speaking countries. These values still carry great influence today, both in society and social policy (Fine and Glendinning 2005, Qureshi & Vernon 2000), and it is correspondingly recognised by critical perspectives (Bracken & Thomas 2000) that tacit 'historical attitudes' can shape contemporary social 'systems and processes' (Minhas 2005, p.73). Consideration of these historical assumptions can therefore potentially tell us much about today's policy understandings of health and social care concerns and their solutions.

The human being in the Enlightenment, came to be equated with 'reason'. This was thought to render the person – in contrast to animals - in complete control of body, emotions and environmental forces (Ingleby 1983), through providing the 'capacity to formulate and pursue plans and purposes which are self determined' (Stainton 2002, p.192). People whose health and social care concerns – especially when linked to mental health - impacted upon their autonomy were thus regarded/treated in society as less than human (Ingleby 1983), due to their apparent lack of 'that power by which we are distinguished from the brutal class of animal creation' (Robinson 1729, cited in Foucault ref). Autonomy was therefore viewed as the basis of positive health and independence through the control it conferred, and consequently, solutions to health and social care concerns lay not in welfare but in subjecting those thought capable of autonomy to learning experiences in the form of education and the inculcation of 'reason' (Scully 1983, Jones 2002). The welfare state replaced this approach with health and welfare entitlements, based on the view that there were limits to autonomy – that people could not fully control the impact of adversity (Kemshall 2002). Today's policy, however, appears to resonate with the Poor Law approach, as expressed in the view that: 'Social investment

in education ... and skill development are ... more efficient mechanisms than ... universal benefits to meet needs' (Kemshall, 2002, 34). And as beings potentially governed by 'reason' rather than body, emotions and social adversity, health and social care concerns are viewed as having in reality minimal impact: as indicated in the recent White Paper (DoH 2006a) people with these concerns are viewed as people for whom services need to 'fit into' their 'busy lives' (p.7)

How helpful is the policy approach?

The above assumptions therefore construct complete individual control of health conditions and social adversity as fundamental to health and social wellbeing, and to the human condition itself. Their influence today has been the focus of major challenges from alternative social models in relation to disabled people, older people and mental. These models identify the basis of disempowerment and disablement not in individual incapacity but in power inequalities which deny the rights and resources, which people require to exert the same control over their lives as non-disabled people (Barnes et al .2002, Barnes and Mercer 2004): in accord with Enlightenment views of disabled people, Finkelstein suggests society sees their lack of control over their lives as ' an attribute that separates us from the normal – we are not quite human' (Finkelstein 1998, p30), and thus discriminates against them.

But what too of the impact of health concerns and adversity upon individuals: are people able, as expected in the Enlightenment and today to manage the impact of their health and social care concerns upon them?

Experiences of health and social care concerns

Research evidence suggests that symptoms can form major barriers to accessing employment and the mainstream in studies, for example, in respect of lone parents (John et al 2001) and people with long term conditions including serious mental health concerns (Qureshi et al. 1998, Platt 2008) - and people with serious mental health problems identify symptoms on a par with discrimination as barriers to employment (Marwaha and Johnson. 2005). People can experience major reductions in motivation and capacity simply through being overwhelmed with pain and fatigue (Crow 1996, Stanley 1999) ' I know I should do my walking and exercises for the heart problem. But I've been feeling so badly...(Just) dealing with my asthma and bowel problem, then trying to recover from this virus, takes everything I've got' . I can't handle anything more' (Chamaz 2006, p.379). Greater severity of symptoms and health concerns is linked both to loss of employment (Dickson 2003), and to failure to self-care: as shown in one study of people with long-term conditions, only 33 % of those with multiple conditions in contrast with 60% of the whole sample adopted such strategies (Ellins and Coulter 2005).

What of emotional distress and the experience of mental health concerns? People with long-term conditions are exposed to these experiences through the losses following from the latter (Mold 2003). Also, significantly, they will have a higher risk of experiencing

'chains of adversity' (Rutter 2000). These start with disadvantage in childhood, linked also to child abuse and neglect (Guterman 2001, cited in Fredrick and Goddard 2007). Together these experiences render the person more vulnerable to poverty in adult life with its increased risk of mental and physical health problems; to domestic violence; to limited capacity across all areas of social participation, and to substance misuse: There were indications that older people with multiple health conditions in Davey's (2005) study, 50% of whom were experiencing depression, had been exposed to such accumulations of adversity. Emotional pain from these different sources of emotional pain has been found to impact upon coping and motivation (Major 2006; Bifulco 2004), and substance misuse: one fifth of dependent drug users in one study used drugs to block abuse memories (Keene 2001), and Larson et al (2007) show emotional pain to be a major correlate of drugs relapse. Significantly too, trauma, as shown in a study of holocaust survivors (Schreiber et al. 2004, cited in Bywaters 2009) contributes to the onset, persistence and severity of serious health concerns, which, as indicated above, themselves impact on capacity.

What of social adversity? Social inequalities and exclusion can limit autonomy, resilience and recovery through restricting access to resources and opportunities (Link and Phelan, 1995). But also poverty 'inflicts massive economic, social and psychological damage' (Novak 2002, p.186). This can be shown in the direct' (Silver et al.1999) consequences of poverty for health – e.g. through malnutrition, poor housing and exposure to other physical conditions (Bywaters 2009); for psychological distress (Walker & Walker 2002), and negative emotions (Test et al.1989). These in turn impact upon coping (Abrams & Curran 2007), motivation (Lipscombe 1997), substance misuse (Test 1989); accessing and sustaining education, employment and networks (Rutter 2000), and making good use of services (Rose, 2006). In addition these groups lack financial resources and social supports, forming important 'protective factors' against the onset of physical and mental health conditions (National Institute for Mental Health in England 2005, White 2003) and disadvantage renders them more vulnerable to the persistence of health concerns (WHO 2005, Jenkins 1992).

The experiences and impact of health concerns and adversity can therefore be seen to act as powerful barriers in their own right to the exercise of capacity and to accessing capacity-building opportunities and interventions, particularly when these concerns are severe. In accord with these experiences, UK and international policies to reverse this process – to counteract the force of these concerns by active, capacity-based approaches - can be called into question by research findings for example, that reduction in lifestyle risk factors accounted for less than half of the improvement in death rates over time in a study of heart disease (Vertanen et al 1998). Findings that it is hard even for the most motivated people engaging in behavioural change interventions, benefitting also from counselling support, to make and sustain more than modest changes to behaviour (Multiple Risk Factor Intervention Trial 1982, cited in White 2003) can also lend support to this view. The powerful impact of severe concerns is highlighted too, in the finding that capacity-building interventions alone can result in relapse amongst people facing severe, long-term health concerns and disadvantage, while people with more advantaged backgrounds are more able to value (Wilson et al. 2007) and positively benefit from such

interventions (Goldberg 1984; Falloon and Marshall 1983).

What is involved in the above experiences of health and social care concerns? In accord with social model of disability critiques, a study by Houston (2004) showed that it was only when disabled people could afford to access all the supports they needed in contrast with people reliant upon public resources, that they could really experience psychological empowerment and exert control over their lives. But crucial too in the above are the barriers to capacity people experience through direct damage to their health, and through physical and emotional pain.

Of great significance in these understandings too, are the connections of many of the above experiences to trauma and post traumatic stress. Post traumatic stress, involving the experience of major threat, usually when trust in a more powerful world, person or organisation to promote ones' interests is breached (Oltmanns & Emery 2001), has been linked to childhood abuse and domestic violence (Finkelhor 1984, Humphries and Thiarra 2004) – increased risks for those with long-term health concerns through the connection of both to poverty. Importantly too, however, the onset of major illness itself, affecting the person's whole life and identity could also be so linked, as an 'assault upon the self' (Charmaz 1983). In addition, older people with long-term health conditions are more vulnerable to adult abuse (Kings College London and the National Council for Social Research 2007). Symptoms of post traumatic stress include dissociation and flashbacks; arousal including panic, terror, agitation, anger and disturbance to eating and sleep, and withdrawal, lack of confidence, phobias and depersonalisation – all of which will undoubtedly increase suffering and decrease capacity.

Experiences of services

Service users thus experience disempowerment, damage and suffering as a consequence of health and social care concerns. How far do policy responses of access to the mainstream, minimal services, de-professionalised social care, independent sector care and educational rather than therapeutic approaches, address these concerns? Many seek more social care services such as transport, help with housework, to support ordinary life and to avoid 'burdening the family' (Age Concern 2006, Platt 2008, Raynes et al. 2001); relief of stressors (Hannigan 1997); specialist resource-centres and opportunities to build their own communities of interest and mutual support (Shaping Our Lives 2003; Perceval and Hanson 2005; Wilson et al. 2007); the professional quality of trustworthiness in care staff (Raynes et al. 2001); professional commitment to their best interests (National Institute for Mental Health in England 2003), and person-centred, specialist understandings of their concerns (Manthorpe et al. 2008, Morris 2004). For some in a study by Pitt et al. (2007) recovery meant 'feeling inwardly all right' (p.57).

Significantly, these service aspirations correspond to the different types of barrier to empowerment discussed above: some relate to the citizenship and social participation aims within current policy - although the responses sought, such as adequate supports for ordinary life activities, and independence from family were more in accord with social model of disability perspectives. Others however relate directly to the experiences of

suffering and damage discussed above: service users sought therapeutic and professional responses to distress, stressors and specialist needs.

What happens when these responses are not made? In accord with Clarke's (2004) identification of abandonment as a major implication of current policy approaches to empowerment, many service users experience betrayal. Parents who sought refuge in a service after fleeing from domestic violence said 'I thought it would be warm and supportive, but the staff here are cold and selfish towards me. I thought I'd be treated right. I feel very bitter' (Tischler et al. 2006, 5).. Similarly, resource-led service decisions lead people to feel 'uncared for' (BBC 2008). Non-professionally qualified staff who are more likely than qualified staff to abuse and hold stigmatising stereotypes of service users (Aitken 1995), and profit-seeking private sector care (Briskman and Cemlyn 2005) can also represent betrayal in the low priority given to the interests of service users seeking help. A different form of betrayal again has been voiced by women who have experienced abuse who have found the focus of interventions on their coping skills uncaring, because their distress does not seem to have been heard (Smith et al. 1998). The impact of such betrayal upon pre-existing post traumatic stress is significant, as it can reactivate the original symptoms (Yehuda 1997), and crucially, as betrayal of the type implicated in the experience of trauma, it has the power to traumatise in its own right.

Service users' service aspirations therefore embrace both the concerns with citizenship and with pain and damage, and significantly seek very different service responses to each. While experiencing shortcomings with services for citizenship, however, with pain and damage policy presents responses which can form the reverse of what service users appear to seek, in accord with historical assumptions that such concerns form the ultimate threat to empowerment.

Looking to a different paradigm

It is suggested here then, that the impact of body, environment and emotions upon empowerment, so minimised in Enlightenment thought and current policy, is great. It is also an aspect of experience for which service users seek a particular set of responses. What does this mean for our understandings of disempowerment – and hence the most effective approaches to empowerment? Freedom (1999), Ham (2004) and others have pointed to two historically influential understandings of social problems, one which matches with current policy understandings, emphasising the person's difficulties in coping with an adverse environment, and the other which traces the problems to the human impact of adverse environments upon individual wellbeing and coping. The research evidence discussed above, suggesting links between the impact of adversity and limited capacity, resonates with the latter, thus suggesting a very different approach to empowerment to that advocated in current policy

Thus what theoretical understandings can embrace these experiences? The social model of disability participates in these understandings, seeking to promote policies which address structural inequalities, redistributing the rights and resources necessary for

disabled people to have real power and control over their lives – an experience which as we have seen, is also strongly linked to positive health.

However, alongside these understandings are theories of structural inequality which not only look at the implications of inequalities for powerlessness, but also for damage and pain – intrinsically connected to powerlessness as we have seen above in relation to trauma, but constituting a separate dimension of it. They also look beyond the social model – once characterised as ‘arid materialism’ (Paterson and Hughes 1999, p.599, cited in Borsay 2002) - to a more multi-dimensional, suffering and human world ‘ravaged by poverty, disease and social conflict’ (Houston 2001, p.848), and trace the implications of all of these ‘public issues’, for ‘private pain’ (Becker & McPherson 1997).

These theories include particular strands of emancipatory theory (Houston 2001, Bhaskar 1978), socio-ecological theory (Labonte 1998) and recent developments in sociology, termed critical realism (Williams 1998). Contrary to the view of the Enlightenment and current policy, these recognise in accord with Wright Mills’ (1970) concept of the sociological imagination, that people’s humanity resides both in their potential to be ‘creative beings’ with capacity for autonomy, while also to be ‘shaped by the world around them’ (Ward 2000, 60). The individual can therefore be subject to the impact of powerful physical, biological, social and interpersonal conditions, while also having the capacity to exert control – although this too will be profoundly affected by conditions. Consequently, these approaches seek to promote empowerment by addressing the ‘conditions leading to or hindering the self-realisation of individuals and social groups’ (Humphries 2005, p.281).

Disempowerment

What then is involved in the damaging impact of social adversity? This is understood by the above theories to involve ‘complex systems’ processes (Healy 2005) in which conditions in one system can trigger consequences in other systems. Thus socio-economic and socio-cultural inequalities can impact upon individual environments and intrapersonal systems through social, psychological and biological processes which create restrictions, damage and suffering over which people have little control. Critical realism therefore suggests for example, that painful emotions engendered by social conditions can play key roles in the emergence of health concerns through having a biological impact: as Williams (1998) suggests, health consequences result from ‘realistic assessments and understandable responses to extreme social circumstances’ (p.65). Bywaters and McCleod (1996) therefore suggest that disadvantaged environments are ‘lived out physically and psychologically (p.16).

These understandings relate to the experiences of health and social care concerns discussed above. Extreme social and psychological stressors are frequently encountered, as we have seen, through chains of adversity, trauma, and the experience of multiple health and social care concerns, and there is, in accord with the realist perspective, a wealth of research evidence demonstrating the impact of such conditions on physical health (Marmot and Wilkinson 1999; WHO 2005): for example the biochemical impact

of emotions linked to job insecurity can lead to heart disease (Williams 1998). Of major significance to our discussion, however, the latter is recognised by policy, but the prevailing view is that capacity can be primary in overcoming these extreme emotions and their consequences (National Institute for Mental Health in England 2005, WHO 2005).

This is to fail to recognise, however, the operation and the force of many of the 'complex systems' processes operating between the individual, her or his inner and outer systems, and wider society. These can be shown to affect not only health, but also capacity, in contrast with the Enlightenment view that human autonomy is relatively immune to these influences. As we have seen, there is evidence that experiences of restricted opportunity, damage and suffering are such as to place severe limits on capacity, and complex systems understandings draw attention to the processes involved. Thus structural inequalities impact on the person's interaction with her or his immediate environments through imposing restrictions on the money, time, resources and opportunities needed to buy and cook nutritious food, and access leisure, activity, and social participation (Bywaters 2009). Equally, intrapersonal experiences of motivation, energy, pain, physical and mental health symptoms, mobility constraints, concentration and distress resulting from the impact of environments will diminish capacity through real processes of damage and pain affecting thought and action. Thus, for example, as many as 45% of disabled people unable to go out reported this as due to physical pain and fatigue (Martin et al. 1991). In relation to mental and emotional distress, post traumatic stress, likely, as we have seen, to affect many people with health and social care concerns, gives rise to biological processes linked to psychotic symptoms, behavioural disturbance, and extreme psychic distress, far beyond 'ordinary' unhappiness (Bhui 2002, Pitman 1997, Yehuda 1997, Walker 1992).

These processes therefore constitute examples of how adverse social, physical and interpersonal conditions can affect capacity. Very importantly, such processes may play a part in explaining the statistical correlations between capacity and active social participation variables and health and social care outcomes informing policy: the adverse conditions giving rise to the above processes are connected as we have seen earlier in this paper both to health and social care outcomes and to capacity, and therefore potentially contribute to the connections between the latter variables.

The significance of these understandings therefore is that complex systems theories can account for the substantial limits to capacity and autonomy recognised by earlier welfare approaches, while also recognising the substantial social contribution to these limitations. Furthermore, the understandings that capacity is affected by processes that are hard to control suggests they form part of human experience, rather than the products of poor individual capacity. These seminal considerations serve to remove the basis for the stigma and segregation attaching to the individual with health and social care problems within earlier approaches, instead revealing the suffering, damage and restriction implicated in these concerns as part of the human condition, calling for an adequate response.

Empowerment

What, then, are the implications of these understandings for optimal policy and practice responses to people facing health and social care concerns? Although as indicated by national and international health and social care policy (WHO 2005; Department of Health 2001), active social participation and lifestyle variables can benefit health, complex systems theories show how the restricting and damaging processes and experiences of pain set in train by a range of inner and outer systems impact on both health and capacity. This suggests that interventions that can address the conditions underpinning these processes, and ameliorate their effects can contribute much to the promotion of empowerment. Such interventions would have the potential to empower both in terms of promoting positive health and social care outcomes, and also, crucially, as a major support to the capacity-building approaches favoured in current policy..

There is a range of evidence suggesting that provision of improved conditions enables people to build their capacity. Studies have shown that medication and treatment relieving symptoms can increase social participation (Qureshi et al 1998) and restore mental capacity (Pedlar 1999) amongst people with mental health concerns; person-centred services and approaches (National Institute for Mental Health in England 2003; National Treatment Agency for Substance Misuse 2002; Secker and Harding 2002, Stanley 2003) can promote capacity, compliance with services, and recovery amongst people experiencing mental and emotional distress, and services obtained by professional brokerage and reduction of social, practical and emotional stressors have been linked to improved health outcomes, reduced hospital admissions and increased independence in mental and physical health contexts. (Bjorkmann and Hanssen 2000, Quilgars 1998, Wanless 2006). Furthermore, drug users in one study became sufficiently motivated to enter treatment when social stressors had been reduced (Elward 1992)

Involved in these responses are many features of the welfare state with their therapeutic, and professional approaches, viewed today as 'passive' (Harris 1999). However, although the service user is 'passive' in relation to them, they form the basis for increased capacity and autonomy in the above studies, in accord with the interactive dynamic of complex systems theory in which the individual is shaped by besides also shaping her or his inner and outer world. And indeed, these responses were based in the welfare state on paradigmatic assumptions resonating strongly with the complex systems theories discussed above: they formed responses both to the person's 'innate worth' linked to autonomy (Hollis 1964, cited in Smith 2001), and the force and impact of adversity, operating through complex processes largely beyond the person's control, to create suffering and damage (Doyal and Gough 1991). Core to these approaches was the 'moral' (Smith 2005) response, affirming users' suffering and 'human worth', through recognition of their 'moral rights and entitlements' (Charmaz 2006: 367, 368) to the person-centred relationship (Seden 2005); to ethical, therapeutic and specialist interventions (Sudbery 2002), and resourced services (Bean 2001). These may be termed restorative in contrast to capacity building approaches.

Complex systems theories thus share with these approaches recognition of the person's

human worth and potential, the reality of suffering and the complex processes involved in disempowerment. However, policy and practice-approaches based on these theories extend these responses beyond welfare state remits in their concern to address the wider 'personal, institutional, cultural and economic' (Dominelli 2002, p.36) experiences of adversity faced by service users. This would involve, intervening with the 'causal mechanisms within the person, their social networks and the wider society, which give rise to suffering and oppression' (Houston 2001, p.853), including work in accord with the social model of disability to transform structural barriers to autonomy, but also to address individual stressors, relieve pain and restore damage with the use of social rights to services with redistributory (Fine & Glendinning 2005) and therapeutic potential. Critical realist understandings of the 'complex systems' processes implicated in the impact of social adversity highlight too, the importance of health and social care collaboration in the above responses.

The above approaches therefore match with many of the service needs voiced by service users in the current policy context – needs on the one hand for professional and therapeutic responses to whole-person suffering and damage, and on the other for more supports and service entitlements enabling them to access citizenship and social participation. This suggests that for many people both sets of concerns have salience to their human identity and thus both responses have significance as human rights.

There are some indications that those who are least affected of the impact of adversity may want and need fewer restorative interventions while those most affected may need a long-term emphasis on these. In accord with this, studies have shown that very often it is a balance of restorative interventions addressing adverse conditions and their effects alongside capacity-building and access to the mainstream which bring empowerment gains (Neale and ref 2002, Scott and Freeman 1992, Audit Commission 1998). But as attested to by many service users in studies discussed in this paper, a failure to respond to pain and damage with 'moral' restorative approaches counts as betrayal in a form linked to trauma– and as we have seen, reactivation of trauma can lead to exacerbated symptoms, and thus still greater disempowerment and lack of well-being.

In emancipatory frameworks too the worker's moral commitment to the person's interests and recognition of her or his personhood presupposes and ensures a genuine partnership and a non-elitist use of specialist knowledge which learns from and is negotiated with the service user (Ward 2000). A response to service users' concern not with segregation but for resource centres with opportunities for 'communities of interest' between service users allows them to articulate, develop and promote their own understandings, as a basis for real involvement individually and collectively in the services (Beresford and Crost 2001).

Conclusions

This paper has therefore reviewed service users' experiences of 'active' policy and practice approaches to empowerment. This has involved an exploration of the barriers service users encounter in relation to these approaches, and thus to improved health and

social wellbeing, in the implications of health concerns and social adversity for suffering, damage and restriction. The impact of the latter has been discussed with reference to complex systems theories which recognise that the human condition encompasses both the capacity to control, and also to be controlled by the multiple systems within and around the person. These understandings suggest that policy and services which seek to address adverse health and social conditions besides capacity-building, have the potential to maximise health and social care outcomes, and to provide the response people view as a human right in the face of suffering. But essentially, they also assert that the individual disempowered by her or his circumstances is fully a citizen, and thus entitled to the resources and opportunities required for this to be a reality.

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