Discuss the evidence that social policy constructs personal lives

Introduction

This essay will explore how the personal lives of mental health service users are shaped by social policies, and how they shape these policies in turn. Social policy has continued to expand and develop alongside the welfare state after the post-war settlement of 1945. Government initiatives have touched the lives of all UK citizens (The Open University, 2009a). The role of the state is changing with the growth of neo-liberal ideology since the 1980s, diversifying and outsourcing to a range of third party agencies. Still, healthcare, education and welfare benefits mean that the trajectories of peoples’ lives are affected by social policy.

Mental health service users’ lives are subject to policies that range from care to control, from out-patient care to in-patient confinement (Goldson, 2004). In recent decades, the mental health service user movement has grown, and the amount of influence people have on the policies that influence them has also changed.

As evidence, this essay uses a small scale case study I carried out which comprised two half hour interviews with ‘Lou’, female, and ‘Mark’, male, who are mental health service users (Bray, 2016a). They are also active agents in influencing mental health policy through their involvement with service user-led groups. I chose this topic as I attend these groups, have shared values, and ‘insider status’ (Churchill et al, 2009a). Mark and Lou are shaped by the care they give and receive, and by their work within mental health, so this essay will focus on the themes of care and work. In addition to these interviews, the essay utilises a personal narrative from my life as a mental health service user and my journey towards accessing social housing (Bray, 2016b). Personal narratives illustrate ‘reflexivity’, where reflecting upon the mutual construction of knowledge is an integral part of the research process (Churchill et al, 2009b). I am both participant and researcher, engaging with the changing nature of mental health care policy.

The question of how mental health service users’ personal lives are constructed through social policy will be explored through an examination of various
themes: policy context, medical and social models of disability, difference, relationships with welfare professionals and singular characteristics. Using post-structuralist and feminist perspectives, the essay shows how social policies and the lived experiences of service users help to construct each other.

Background

The term ‘social policy’ encompasses government and third-sector initiatives and the study of their causes and consequences (Lewis and Fink, 2009) Social policies are designed to provide welfare, but are contested, ambiguous, and subject to change over time. They are also instrumental in social control. Personal lives are moulded and shaped by social policy. A common-sense understanding of ‘the personal’ is the private, unique aspect of an individual’s life (The Open University, 2009b). Closer examination reveals complex sets of relations with social policies that constrain and enable people’s choices. What constitutes personal life is contingent upon the relationship between social structure and personal agency. Individual life stories are contextualised within wider social patterns, yet people respond in idiosyncratic ways to them. ‘The personal’ can be examined through four domains that illustrate the intersections with the social: social discourses; norms, assumptions and values; social divisions; and emotional and psychic states (Lewis et al, 2009). Social policies are ‘mutually constituted’ through being made and remade by individuals, as policy makers, welfare professionals and service users (Lewis and Fink, 2009). However, this is not an equal relationship, as power is not distributed evenly between the state and the individual. Entanglements of social policy and personal lives can be examined at three levels. National/state level is where government social policy legitimates or problematizes personal lives. Service level illustrates how welfare professionals influence the enactment of policy. Finally, the individual level illustrates how people negotiate the effects of social policy.

Different epistemological positions ask different questions about what constitutes knowledge (Churchill et al, 2009b). In illustrating the construction of personal lives and social policy an inductive process has been carried out in analysing interviews and personal narrative (Churchill et al, 2009a). This is where exploratory data is produced, then explanations emerge from there. The qualitative methods used in this approach draw out depth, meaning and detail from a participants’ viewpoint. In the case study, I used a flexible design with semi-structured interviews which allowed the participants to construct
narratives (Newman and Mooney, 2004). The topic was set by myself as researcher but the questions were open to allow flexibility (Bray, 2016a). In contrast, a positivist approach is to set categories in advance which are counted and expressed numerically. These quantitative methods are useful for large data sets studying populations and shows broad social patterns, but do not reveal more complex narratives. Personal narratives and interviews cannot be generalized, and may be filtered through memory. As a researcher, I influenced the social construction of knowledge together with the participants through the questions I asked and their responses. A subject position as fellow service user means I interpreted information that an independent researcher may not. It is also possible that our shared knowledge means that some things may not have been explicitly stated.

Two theoretical perspectives have been used for analysis. Firstly, a post-structural approach enables questions to be asked about what counts as knowledge. Through the power of discourses, individuals are constructed as inhabiting particular subject positions, such as ‘mental health service user’, yet they can choose to resist being constituted as such. Discourses are the ways in which a subject is thought and spoken about. According to Foucault (1990), language produces meanings that are taken to be the ‘truth’ of an issue, which is a powerful process as it has material outcomes (Carabine, 2004). There is power in the ability to classify and define. Thus knowledge is constituted through discourses and is produced by, and productive of, power (Lewis et al, 2009). In addition, feminist perspectives are concerned with the socially constructed categories of gender, and in particular how women are subordinated to men, who hold greater power. Feminist research has brought to the fore the ways in which ‘the personal is political’ (Lewis et al, 2009, p.52). The public/private duality is challenged in addressing inequalities. Care work with mental health services blurs the boundaries between the private, domestic sphere and the public world of the workplace. Both approaches shed light upon differing aspects of structural and individual power relations.

Policy context

The first theme in exploring how personal lives are constructed is the social policy context, where changing initiatives over time have affected people’s lives. There has been a policy shift from the provision of universal services to a more individually-based focus delivered through the markets. Previously, in 1942, The Beveridge Report was influential in the formation of the welfare
state, establishing universal provision of insurance benefits for “disease and accident” (Beveridge, 1942, cited in Fink, 2004, p.30). Addressing incapacity, he expressed a moral judgement that there is a financial imperative to be a “stimulus to prevention” (Beveridge, 1942, cited in Fink, 2004, p.30). Yet the Labour post-war settlement meant that medical definitions of disability removed moral responsibility for incapacity. A policy document in which Beveridge sets out his proposals illustrates this argument (Fink, 2004). Another form of qualitative evidence, documents give an insight into the purportedly authoritative social policies of the time. In the 1980s, the neo-liberal ideology of Thatcher’s Conservative government saw state services become “enabling agencies” rather than providers of care (Fink, 2004, p.31). Continuing up to the present day, managerialism has been introduced into healthcare: the state maintains control in the evaluation, assessment and access to a range of services, but the practices of welfare management accord with those of business (Mooney, 2004).

Embedded in the National Health and Community Care Act 1990, mental health service users were to be cared for in and by the community rather than in institutions (Fink, 2004, p.31). Evidence from my case study interviews shows how tensions within this political context made formation of service user-led groups possible, thus shaping their personal lives. Mark’s work with a group began “in a hospital that was closing” (Bray, 2016a, Mark, lines 54-55). This is a qualitative account, whereas quantitative research methods would provide a fuller picture of how many hospitals closed, and how many service users were affected. As a worker for the NHS, Mark had to justify funding year after year (Bray, 2016a, Mark, lines 200-2004). In Lou’s opinion “it was a massively politically driven initiative to save money…with massively insufficient levels of support” but “in terms of the pure ideology I totally agree with it” (Bray, 2016a, Lou, lines 360-370). Lou’s mixed attitude toward the policy changes illustrate the tensions within implementation.

Medical and social models of disability

The second theme illustrates how classification can construct personal lives. Discourses create subject positions such as ‘mental patient’, imbued with meanings, ‘vulnerable’, or ‘dangerous’. Using this post-structuralist perspective it can be argued that the medical profession constructs a discourse of scientific knowledge that operates through professional power (Lewis and Fink, 2009). The ‘clinical gaze’ labels individuals through the process of diagnoses which
have the power to determine life-chances. Categorisation and classification identifies normal and abnormal behaviour. Normalization is where individuals are compared against a desirable standard which has a disciplinary effect, as a form of social control that threatens social exclusion. Medical ownership of medical health conditions goes back to the Mental Deficiency Act of 1913 which defined the ‘mad’ and ‘defective’ (The Open University, 2009c). At the time there was a binary opposition between mad/sane. Even though more complex today, being ‘sane’ is the desirable, more valued state. This medical model of disability uses expert knowledge to position patients as vulnerable and dependent. Visible in evidence from my personal narrative, access to housing services was only possible after my classification as “medically vulnerable” (Bray, 2016b). These classifications and subject positions lead to provision of services that help service users, but they also serve to stigmatize. Service users become marginalized and positioned as different from the norm.

Dominant discourses are contested through resistance and activism. Discourses are not fixed or unchallenged, counter-discourses are responses to hegemonic ways of thought. Medical discourses may be seen as expert, but they are contested, for example by the service user movement and discourses of empowerment (Newman and Mooney, 2004). Throughout the Conservative and Labour governments of the late 20th Century, alongside managerialism and accountability, an ideology of consumerism, where individuals became constructed as customers, gained popularity in social policy. The NHS began conducting consultations with service users, as seen in the case study, where Lou’s life was changed by being asked to “comment on some draft and policy documents for the Trust” (Bray, 2016a, Lou, lines 16-18). Shaping the direction of her personal life, she became active in service user involvement. Evidence here suggests that her choices were influenced by policy initiatives. Empowerment goes further, however, by challenging the authoritative knowledge of professionals from the bottom up by those with lived experience. Mark attempts to work with his clients “in a kind of integrative way” (Bray, 2016a, Mark, lines 369-370).

The participants challenge the medical model with the social model of disability, which includes taking into account the influence of economic and cultural factors in disability (The Open University 2009d). These processes are seen to shape mental health issues rather than factors innate to the individual, within a society dominated by a ‘sane’ norm. The effect is of socially including
mental health service users rather than seeing them as ‘other’. Lou describes “a non-medical model that… focuses on my strengths instead of focusing on my deficiencies and pathologies” (Bray, 2016a, Lou, lines 135-139). The participants illustrate there is always an ‘excess’, where people do not act in accordance with social patterns created by processes of power and inequality (Lewis and Fink, 2009). Representing counter-discourses in qualitative research can be political, giving voice to alternative value systems to promote social change (Churchill et al, 2009a).

**Difference**

The third theme explores the multiple ways in which personal lives can be affected by policy. Social divisions such as gender, class, ethnicity and disability interact to construct personal experience (Lewis and Fink, 2009). The allocation of public resources and access to services differs along these lines, affecting life-chances and shaping opportunities. Using a feminist perspective, power lies within the patriarchy, a social system where power is unequally distributed towards men (Lewis et al, 2009). Normative assumptions of care are that it is an unpaid activity that takes place in the home, undertaken by women (Fink, 2004). Assumptions about work are of a paid activity in the public sphere (The Open University, 2009e). Socially constructed differences of gender have consequences for different occupations within the mental health system. Although this is in the process of changing, men have more positions as doctors and managers. Women traditionally drive the service level, nurses and therapists (Newman and Mooney, 2004). In my case study, Lou mentions groups “full of middle class white women that have had the briefest of contact with services and…feel they can represent all service users” (Bray, 2016a, Lou, lines 89-93). Yet this is changing over time with more men such as Mark, as a mental health worker, taking positions in traditionally female domains. In an empirical study by Twigg (2000), male carers were shown to have a problematic experience in the way women do not as “all male workers are to some degree under suspicion” (cited in Fink, 2004, p.11). They are assumed to be predatory.

The intersection of disability with gender is the area in which ‘Housing For Women’ operates, the housing association discussed in my personal narrative (Bray, 2016b). The organisation recognises gender inequalities alongside mental illness that contribute to homelessness, and attempts to redistribute resources to balance this. From a post-structuralist perspective, the imbalance of power in the binary division of service user/non-service user has the most effect on the
participants’ lives. The power to classify is at the heart of hierarchical structures, and operates in a regulatory fashion, assigning one group lower value than the other. The social division of disability creates an inequality of status and pay. When asked to participate in a work project, Lou commented that “external people will be offered lecturer’s rates and we’ll be offered luncheon vouchers”. Individuals’ experiences of difference are not homogenous, however. Mark celebrated his unique qualities as he was “from Singapore and we all think magically there” (Bray, 2016a, Mark, 127-128). He rejected the label of service user and the white British normative discourse of mental illness by making sense of his situation as ‘other’ (Lewis et al, 2009).

On a national/state level of mutual constitution, social policies are replete with assumptions about personal lives. If the personal life of an individual is deemed deviant from the norm, interventions and scrutiny by the state are implemented. However, collective action can alter the course of policy. In the Beveridge Report (1942) he sets out the rights and responsibilities for the ideal citizen to be supported by the welfare state. This worker-citizen is constructed as a male breadwinner who supports a wife and children as dependents (Mooney, 2004). Women are tied to the private domestic sphere, which was taken to be the prevailing norm of the time. People’s behaviour over subsequent decades has not conformed to this and the adult-worker model, with two incomes in a family is becoming supported in policy (Fink, 2004). However, in my personal narrative, I do not fit either model, and am used to living “an independent life” (Bray, 2016b). The formation of a women’s housing association in 1937 was achieved by activists to provide female-only tenancies where “the rights all belong to the women”. This expanded the boundaries of wider social patterns expected of women in the normative social discourse, showing ‘excess’.

‘Housing For Women’ is an example of an alternative groups developing and changing the course of social housing policy.

Relationships with welfare professionals

The fourth theme explores the service level, where two way processes of shaping personal lives and social policy are enmeshed (Lewis and Fink, 2009). Welfare professionals connect with personal lives where they are defined as in need. In these complex circumstances, they are agents that judge entitlement and are state gatekeepers to services. My personal life is subject to several assessments and referrals that pronounce me ‘deserving’ of housing services because I am medically vulnerable, not culpable (Mooney, 2004). It takes a few
“difficult years” of classification and conditionality before I qualify (Bray, 2016b). The assumptions of ‘deserving’ and undeserving’ as seen in my personal narrative are embedded within policy discourse. These assumptions originate from who is able to be reformed through a work ethic and who is resistant or deviant. Medically however, this line is blurred between who ‘deserves’ care and who does not. Mental health service users are again constructed as vulnerable. However, in my case study, the service users were also welfare professionals negotiating their way through encounters with both professionals and other service users.

Each welfare professional brings their own personal life to bear when they meet service users (Lewis and Fink, 2009). Consultations may take place, but they do not necessarily give away power, so decisions ultimately lie with the professional (Newman and Mooney, 2004). In order to cope with this, emotional labour takes place, where individuals must manage the emotions that are brought up during their work (Mooney, 2004). They perform a particular ‘self’ for their job. As care work is devalued, this emotional element is rarely recognised financially (Fink, 2004). Also, emotional management can lead to decisions that do not necessarily accord with policy or the service user. In the case study, policy was impeded by welfare professionals who didn’t prioritise the implementation of the policy of consulting service users. They brought personal understandings that were different. Lou remarked that although the employees of the NHS Trust were good at “talking the talk about service user involvement.. they were extremely hostile to service users” (Bray, 2016a, Lou, lines 174-180). Mark notes that for the Trust, “one of the most common complaints is that we don’t listen” (Bray, 2016a, Mark, lines 485-486). In an empirical research study, Lyth, (1988) found that nurses defended themselves against anxiety evoked in their work by creating distance thereby “eliminating risk” (Lyth, 1988, cited in Fink, 2004, p.21). They shut down as a defence against anxiety and adopted a brusque attitude. Although this study was not with mental health service users, it helps to illustrate how connections between professionals and service users become enmeshed. A post-structuralist approach highlights the management and performance of the self within changing discourses. To be constructed as caring and dedicated at all times may not be actualised with each service user. However, as Lou comments, “it’s all about the relationship” (Bray, 2016a, Lou, lines 318-319). The influence upon the delivery of policy is fundamental to how individuals implement and design it in future.
Singular characteristics

Each individual responds in unique ways in being influenced by and influencing policy. Mental health policies that label and intervene in an individuals’ personal life can shape the emotional and psychic landscape (Lewis et al, 2009). Treatments can be invasive, and compulsory, in an attempt to produce normative behaviour. This is a form of ‘governmentality’, a concept from post-structuralist theory that explains how capillaries of power may urge an individual to “control one’s own instincts” (Rose, 1999, cited in Lewis et al, 2009, p.66). Governmentality includes all attempts to shape others’ behaviour. Therapy is an example of this, where the aim is to alter the individuals’ psyche and emotional life. But in the case study Lou shows that governmentality is not a straight forward power relation. She describes a “partnership” with a therapist where they are “looking at current behaviours thoughts and feelings and looking at changing them” (Bray, 2016a, Lou, lines 226-229) She accepts this intervention as she doesn’t feel any “power imbalance” (Bray, 2016a, Lou, lines 231-232). However, the subject position of mental health service user carries stigma, and this can prevent people from accessing services.

Times of intervention can be very stressful and create fear in the service user. As Lou admits, “there’s massive shame about it” (Bray, 2016a, Lou, lines 404-405). The shame is felt by my family about my father’s mental illness, as illustrated in my personal narrative. “We always tried to keep this as secret as possible…there was so much stigma attached to mental illness” (Bray, 2016b). The family received no support from social services. A process of ‘passing’, where the public image of an individual disguises membership of a stigmatized group occurred (Lewis, 2004, p.20). Fear and psychic defences against anxiety shape the emotional self for future experiences. Additionally, these reactions affect the ways in which policy is enacted.

On an individual/group level of mutual constitution, people construct their own realities which in turn shape the nature of social policy. Active citizenship can expand discourses within which mental health service users are constituted (Newman and Mooney, 2004). Discourses are productive of power, and the participants in my case study shift the balance by influencing the service level of personal lives and policy entanglements (Carabine, 2004). Contributing to social life accords with a wider policy shift towards people being responsible
for themselves in all areas of the welfare state (Widdowson, 2004). In my case study, the participants are members of service user-led groups that aim to shape social policy. They see themselves as equals with welfare professionals, “in partnership towards a shared goal” (Bray, 2016a, Lou, line 245).

In my personal narrative, serving on a tenants’ panel gives an alternative to the everyday practices of the assumptions surrounding the worker-citizen. Rather than the male breadwinner model with the normative nuclear family, all the women have a say in their day-to-day running of the flats. Individuals also exercise their agency through ‘excess’ in a way that is deeply personal. In my case study Mark does not identify with the label ‘service user’ or the subject position of ‘mentally ill’. Instead, he makes sense of his experiences in a way that can only be gleaned through qualitative research, “I don’t really call them my voices…the presence of the others… created a coherent narrative out of an incredibly fragmented invalidating life” (Bray, 2016a, Mark, lines 562-568). Mark constructs a counter-discourse where his experiences are positive and not pathological, complicating expert knowledge of the medical model of mental illness.

**Conclusion**

There is evidence that the personal lives of mental health service users are constructed by social policy as they are influenced by political decisions and the services they can access. However, they display variable and multi-faceted aspects of personal agency and people play their part in shaping social policy. This is not equal, as the making and re-making of social policy is contingent upon power relations and aspects of social control. Qualitative methodology is useful to bring out nuances of meaning inherent in the making of personal lives as opposed to quantitative methods which imposes categories on data. However, utilising quantitative evidence may expand knowledges about social patterns and the occurrence of phenomena. This essay used interviews and narrative to illustrate the various understandings of mental health service users, all of whom are working in the field of service user involvement attempting to influence policy and service delivery. These service user-led groups began to develop against a backdrop of the policy shift toward community care and personal responsibility in social life. The concept of discourse highlights how expert knowledge of mental health conditions is prevalent but does not go unchallenged. There is tension between the medical and the social model of
disability. Normalizing discourses of care assume that mental health conditions are supported by women in the private sphere. Feminist perspectives help to illuminate how the boundaries between the public and the private spheres are unstable and are socially constructed. They shed light on the formation of a female only housing association in my personal narrative as an example of ‘excess’. Post-structuralism, however, is less concerned with power that is distributed along lines of wider social structures such as gender. It explains how power is distributed through everyday encounters, between welfare professionals and service users. Individuals construct their own identities and can expand social discourses through active citizenship. Accepting or rejecting subject positions created around them by language, people negotiate their way through social policy advances.

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References


