Article title: **The Human Search for Belonging**

Authors:
Lynda Shevellar: Lecturer, Community Development Unit,
The University of Queensland, Brisbane.
Jane Sherwin: Consultant, Sherwin & Associates, Brisbane.
Neil Barringham: Manager, A Place to Belong (Anglicare Southern
Queensland) and Inclusion Worker.

Corresponding author: Dr Lynda Shevellar
Community Development Unit,
School of Social Work and Human Services,
The University of Queensland
St Lucia, Qld, 4072
Australia
Tel. +61 7 33 65 2316
Fax. +61 7 3365 1788
Email: l.shevellar@uq.edu.au

Statement of originality: This manuscript has not been published elsewhere and has not been submitted simultaneously for publication elsewhere.

Suggested running head: The Human Search for Belonging

Abstract:

Belonging is a human need, yet one that is often unmet for people with significant mental health issues; typically people experience high levels of exclusion. Using a case study approach this research gives voice to people with significant mental health issues about their experience of belonging, with specific reference to their relationships with ordinary citizens, their sense of identity and their sense of meaning in life. Drawing upon a theoretical and practice framework of belonging, the research identifies key principles that support inclusion. It also posits the conundrum of 'belonging to the service', for consideration by progressive thinkers and practitioners.

The Human Search for Belonging

Introduction

There is a body of literature that speaks to the importance of belonging to ordinary, everyday community and the dangers of services that lead people out of, rather than into, community (Armstrong & Shevellar 2006; Flynn & Lemay 1999, Illich, 1987; Lemay 2009; Wolfensberger, 2012). McKnight (1995, p. 123) powerfully articulates that the guiding vision for all service recipients should be:

> 'nothing less than a life surrounded by the richness of diversity of community. A collective life. A common life. An everyday life. A powerful life that gains its joy from the creativity and connectedness that comes when we join in association to create an inclusive world.'

One of the core principles of the United Nations Convention on the Rights of Persons with Disabilities, (2006) is full participation and inclusion in community life. The Convention asserts rights such as 'Living independently and being included in the community', 'Participation in political and public life' and 'Participation in cultural life, recreation, leisure and sport'. Yet commentators have also observed that the assertion of rights has not necessarily translated to changes to the lived experience of people with disabilities, including those with mental health challenges. As Sherwin observes, 'There is professed enthusiasm, but little progress, for people with a devalued status to experience community membership and belonging' (2011, p. 22). Much depends upon the translation of policy to practice by those actually implementing policy in their everyday work (Lipsky 2010).

Definitions of social exclusion appear to focus either on the behaviour of the excluded individual or alternatively on the behaviour of the community that excludes. The way in which social exclusion is defined is likely to affect the approach practitioners take to

inclusive practice – from individualistic strategies through to more collectivist ways of working (Bacci, 2009; Berry et al 2010).

Bertram (2008) asked 150 individuals who receive assistance from a mental health service about what social inclusion meant to them and the extent to which a mental health service should respond to the experience of social exclusion. There was a range of definitions given, and Bertram concludes that greater self confidence, relationships, participating in ordinary activities and financial security were key. Further, he concludes that in order for mental health services to be more helpful, attention should be paid to the nature of the relationship between worker and person such that greater authority, autonomy and living a better life is possible.

Over the last decade, the social inclusion agenda has gained momentum as a policy driver in mental health services. In the UK, the Social Inclusion Unit 2004 report *Mental Health and Social Inclusion* highlighted associations between social exclusion and mental health problems. More worryingly, the report also suggested that mental health practitioners might actually be contributing to the social exclusion of people with mental health problems (Office of the Deputy Prime Minister 2004). In Australia the link between social inclusion, health and wellbeing is recognised through a national Social Inclusion Agenda, as outlined in the *A Stronger, Fairer Australia* (Commonwealth of Australia, 2009). The agenda proposes strategies for social inclusion that encompass participation in education and training, in employment, in voluntary work and in family and caring; engaging by using local community resources; and having a voice so that people can influence the decisions that affect them. This agenda highlights the connection between social and economic disadvantage and the 'multiple, complex and interconnected barriers to participation' (p. 4).

Frameworks for Social Inclusion in mental health services

Prominent critics have argued that the human service sector is dominated by a pattern of service designs that keep people passive and isolated rather than connected and enabled (Illich, 1987; McKnight, 1995; Wolfensberger, 2012). Typically social workers and helping professionals have few models to draw from to assist them in assisting others to establish or maintain friendships and relationships (Gulcur, 2007). This is lamentable as relationships contribute to a sense of depth and wholeness. Numerous studies have demonstrated that good social relationships have a positive influence on mental health and wellbeing (Furman et al 2009).

Some recent work, however, has been done to suggest the development of practice models that support social inclusion (see for example Repper & Perkins 2003 and Salzer & Baron 2006). Some of the work around inclusion and community development brings people with mental health issues together for empowerment purposes, such as described by Seebohm et al (2012). Fieldhouse (2012) highlights the importance of collaboration and joint planning between agencies to increase the likelihood of social inclusion. Carling (1995) suggests that the work of social inclusion and connectedness needs to happen at a number of levels. Firstly, stable and affordable housing needs to be available; secondly, there needs to be access to meaningful employment or vocational expression; thirdly, support services need to be available, flexible and reliable; fourthly, decisions about housing, work, social networks and services must be based on each individual's choices, goals and needs.

 The research that underpins this article focuses on a fifth aspect of Carling's work – that of working towards community inclusion and belonging through the facilitation of freely-given, non-paid relationships with broader community members in ordinary settings around meaningful tasks or roles. It examines the way in which the global social inclusion agenda is being played out at a local level, by focusing upon the perspectives of mental health

service participants and the efforts of one small service. It discusses service participant's perceptions about the assistance they receive from a small mental health service in Brisbane, Australia, and their experiences of social inclusion.

Methodology: A case study approach

To explore approaches to and outcomes of Carling's fifth level of inclusion work, a small Brisbane based mental health network (see www.aplacetobelong.org.au) was chosen as a case study for investigation into belonging . *A Place to Belong,* administered by Anglicare Southern Queensland, provides a service to people with significant levels of need due to their mental health and social issues). The agency was chosen because of its explicit emphasis upon belonging and its conscious incorporation of community development and recovery frameworks into its work.

The research held a dual purpose. For the agency, A Place to Belong, it provided a 'service user assessment'. In essence this provided a means of capturing the voices of people accessing the service and enabled their experiences of the service to be heard by the service provider. It provided a means of testing assumptions held about the work being done and its effectiveness. In short this process asked the question 'In what ways is the agency making a difference in people's experience of belonging?' Secondly, at a theoretical level, it enabled the researchers to better understand the experience of people with mental health challenges in their human quest to belong. The research was conducted by an academic and an independent consultant, both with extensive experience working alongside people with disability and mental health challenges and in conducting human service reviews.

As the aim of the research was to hear people's stories and experiences and understand the idea of belonging through their eyes, an interpretive approach was utilised. The research employed interviews, participant observation and transect walks (a participatory

rural appraisal method). In the context of this research, 'participants' refers to those people receiving a service and were participating in the research.

All people assisted by the agency were invited to contribute via a letter from the service manager. Out of a potential pool of 24 people supported directly by the agency, 15 people agreed to participate. Research participants had been involved with the agency for periods ranging from two months to approximately 12 years. Face-to-face conversations were held with 14 of the 15 participants in locations and times that were convenient to the participants. This meant that six participants were met in cafes; two were met at the agency office; one was met in their public housing flat. One person was met in each of the following: a caravan park, a long stay institution and a secure unit on hospital grounds. Two participants[1] were met in (what is referred to as) transition accommodation. One participant communicated via email.

The over-riding concern of the work was to ensure participants felt safe and secure and were comfortable in sharing their ideas. This meant that the research methodology had to be highly flexible to accommodate participants' personal preferences, health needs, literacy, and communication skills. Consequently the data collection period ran for three months and included a number of rescheduled interviews due to fluctuations in participants' health and wellbeing. To maximise their sense of safety the arrangement with research participants was that they could have whoever they liked with them. Consequently, some were met alone; some were met with a worker present; others were met with allies. The interviews lasted between one hour and three hours. Most were 1.5 hours. Interviews were semi-structured, and sought to understand something of the life events that brought participants to the support agency, what they did with the agency, the people in their lives and how they met them, and the views and images that the person had of the agency and its work to assist them to belong.

---

[1] One participant had left an institution and the other had left a hospital secure mental health facility

A range of means was used to engage research participants: pen and paper diagrams of relationship circles and lifelines; and the use of metaphor cards[2]. Sometimes participants drew their own diagrams, others directed the interviewer to draw or write on their behalf. One participant sent an email in response to written questions. The researchers were open to interpretive comments and explanations from whoever accompanied the participant. Such comments were either to clarify the speech of the participant or to fill in the gaps. Transect walks were used whereby the participant took the reviewer for a walk through their community, demonstrating places and people who welcomed them and assisted them to belong. The research did not examine personal records, or operational elements of the service. The researchers also made observations of workers and their interactions. Observation was not used as an assessment of the worker's performance, but rather to inform the reviewers' understanding of the roles and relationships participants were in, and some of the strategies being used to strengthen these. Utilising these different methods ensured that participants' voices were heard. The insights drawn from these discussions are presented below.

Insights into Belonging

There were four sets of insights to emerge from the research. The first speaks to who the people are and their broad experiences of community and belonging. The second set of insights is about what it means for people to belong and how people struggling with mental health challenges and their own recovery, understand belonging. The third set is about what a human service can do to support belonging in the community. Finally, the research surfaced an issue for progressive practitioners.

---

[2] St Luke's 'Picture this' strengths cards were used with some participants who had a preference for visual over verbal messages. Participants were invited to choose a picture that best described what they were thinking or feeling. See: http://www.innovativeresources.org/Pages/Our_Publications/Card_Range.aspx

1) People's experiences of relationships and belonging

The first set of insights relates to people's experiences of relationships and belonging. The effects of life experiences were either named directly by the participant or their ally or discerned by the researchers. While each participant is clearly an individual with individual life experiences, there were similarities in the paths that life had taken that then led participants to seek agency support. Two key turning points in participants' lives were the acquisition of an impairment of some kind rejection by or of people one can typically rely on, such as family.

Many of the people interviewed had poor schooling experiences, though at least one person had done extremely well at school. Being labelled, ostracised and being given messages about being useless and worthless were also common experiences and are forms of rejection. Rejection had occurred not only within family units but at a system and community level as well. For example, one participant with a severe literacy problem said that she *'could not do this world',* reflecting on the reliance on literacy to function easily in community life. Another participant referred to himself *as 'the boy in the bubble'*, referring to how the typical way that the world worked was hostile to his physical health.

The experience of moving from the family home to share houses and eventually to one's own home, from study to work, to marriage and family, which is a typical life path for most people in western communities, was not common for the participants we met. Many had experienced homelessness and even now, many had tenuous housing situations, made vulnerable because of their own behaviour or the whims of the rental market. Most were poor, having to rely on pensions or very part time work. This is particularly problematic for people with health issues and additional medical expenses, and it also adds to housing vulnerability.

When one looks at the life paths of most of the people who met with the researchers, it is clear that many people interviewed have missed out on ordinary developmental and relationship experiences that are likely to bring a sense of wholesome identity, security, and confidence. In fact, people are likely to have been harmed through their experiences both in community and in human service systems. The experience of relationships appears to have been very fraught. Some participants had experienced abusive families others had experienced fractured family relationships.

Once 'in the system', people with mental health challenges are likely to have very little control over their own lives and their support arrangements. Participants talked about the power held by psychiatrists and nurses. One participant reflected, *'a psychiatrist is in such a powerful position that people are too scared to tell them things'*.

There were also stories that illustrated how life becomes narrowed not because of people's own limitations, but because of the limitations of the support arrangements that are put in place through occupational health and safety measures, funding limitations, staffing needs, the timing and nature of activities, and the needs of other residents of a facility.

Relationships with paid professionals were also frequently disempowering experiences, as many participants had been subjected to control through medication, through incarceration, and through being moved about within the system. One can only imagine the number of professionals, each professing care and commitment, who have moved through someone's life. Similarly unsatisfactory and frustrating interactions with housing services, government agencies, hospitals and mental health services, are likely to have increased the number of 'helping professionals' to have entered and exited participants' lives. Limited or interrupted education and work patterns further impaired the potential for relationship development.

This demoralising list of common experiences across the research participants provides a picture of why belonging is so difficult as well as why it is so vital.

2) What belonging means

The second set of insights from this research supports the idea of people experiencing belonging in three forms: belonging to self, belonging to others and belonging to a greater scheme of things or something beyond us. These three forms speak of our human search for self-acceptance and identity (belonging to one 's self), our search for transcendence (belonging to something beyond one's self), and our search for intimacy and community (belonging to others) (for further discussion of this framework see Barringham & Barringham 2002, p. 55).

Firstly, participants identified ways they saw belonging as belonging to self. This was expressed in terms of having opportunities for ongoing learning and growth and seeking a better life. There was also a physicality aspect to belonging to one's self: a need for bodily safety and security and better health. People expressed a need for income that is adequate for their needs and interests and a better lifestyle. Interestingly, the people interviewed did not express cravings for material luxury, however they did hope for adequate material possessions and things that are an expression of themselves. Similarly, they spoke to the need for a real home that is an expression of their unique personality and which has the feel and security of 'home', not simply 'housing'.

The second way people expressed belonging was in terms of a belonging to the world or to something greater than themselves, to spirituality or to the cosmos. People sought to find purpose and meaning in their existence. They also sought to give back to the world. As one woman explained, *'Before I was lonely and afraid. Now I want to know how I can support others.'*

Thirdly, participants spoke of ways in which they desired to belong to a community. For example, people spoke of the need for a range of relationships: love relationships, friends, and acquaintances. They wanted to offer and receive love, liking and respect, to be regarded positively and have people believe in them. Expressions of community belonging differed dramatically, with some seeking to be known and warmly welcomed by many, while for others belonging meant being known deeply and personally by a few. For some this was also named as a desire for more physical presence in the community, and to be able to navigate the typical community, geographically and functionally. They wanted to be able to move around to see people and fulfil their roles. Significantly not one person said they did not want to belong, did not wish for love or relationships, or wanted to be left alone.

3) How human services can support belonging

The findings above and understanding the three ways in which people expressed a sense of belonging provide a useful foundation to interpret the third set of findings from the research, namely the constructive opportunities available to human services to strengthen and deepen a sense of belonging. Strategies are identified for each of three forms of belonging: providing support to enable belonging to one's self, to enable belonging to the world or a higher power, and belonging to others in community.

(i)   Support 'belonging to one's self'

A sense of belonging to one's self is possible through strengthening one's identity through being in valued roles, through appreciating one's identity based on how one is treated, and through telling one's story.

    a) Strengthen the sense of identity through being in valued roles

Human services can help create a sense of belonging by helping to expand the identity of the people being supported. As described in the previous section, one's identity and sense of

self can be significantly impacted by the experience of mental illness. It was therefore seen that the following were positive and helpful features because they contributed to participants holding a more positive identity beyond that of patient or client.

Several people demonstrated that life had improved through the acquisition of more valued roles, and the accompanying benefits this brings. For example, two people had moved from being homeless and unemployed to being in the roles of tenant and part-time workers, and both have aspirations of even better jobs. Another was assisted to develop his interests to connect to people who share his passions, thereby having an identity in his community of interest, and to connect to others in his neighbourhood which strengthened his local identity.

Part of acquiring and strengthening roles was also the strengthening of skills that accompanied these. One story was told of how the person being supported had previously caused high levels of distress and anger to his neighbours because he couldn't get into his house late at night and used to make high levels of noise. Workers have helped him learn how to enter his house quietly, using his own key, helping him to learn to be a respectful neighbour. At first glance, this looks insignificant, but appreciating the man's vulnerability to homelessness, this small skill is vital to him keeping his home, ensuring his role of tenant and good neighbour, and avoiding eviction.

b) Enable people to get a 'sense of oneself by how others relate to you'

Beyond the labels and diagnoses is the shared human identity. How a relationship is transacted, human to human, is vital as those transactions give messages about a person's identity.

Participants regained a sense of their identity by how community members related to and with them. For example, a local pharmacist welcomes a person with significant mental health issues that at times overwhelms her, and provides a welcome and quiet space for debriefing

and support. A café owner gladly allowed her café to be used as a celebratory birthday venue for a man supported by the agency, and provided the catering. An ally of a person incarcerated in a secure unit took a gift of specifically chosen magazines about one of the person's interests to him. These stories of welcome affirm the dignity, shared humanity and worthwhileness of the individuals in their own eyes.

We also heard frequent stories that affirmed the role of the agency workers in assisting this process. In reflecting upon her experience with the service, one participant said *'I find acceptance for who I am'*. The reciprocal relationship also helped people's sense of identity. As one person explained, *'One nice thing about [the worker] is that he believes that he can learn from people with a mental illness'*.

An important part of this transaction is that the identity of participants was understood by workers at a deeper level beyond the labels relating to mental illness, physical or intellectual impairments or anti-social deeds. One person said *'they don't put labels on me'*. In fact, during the whole research process the researchers heard no labels being used by workers. There were no medical or psychiatric labels or diagnoses referred to, and no derogatory terms or private descriptors for people.

One participant reflected that after the diagnosis and a period of hospitalisation, she had a high sense of insecurity about how people would accept her. She found that the workers were *'affirming and accepting'* and that that was very helpful for her sense of self. When asked what had been done to assist her, one person used expressions like *'there is no right and wrong, they are non-judgmental and accepting, there's no pressure; they take away any sense of needing to get things right'*, *'they encouraged me'*, *'they helped build my confidence'*. She explained that *'because I can trust people there, I can start to trust people elsewhere as well'*.

13

In human services, emphasis is often placed upon what workers do. What these findings reveal is how vital are two characteristics: the qualities that the worker brings to the relationship, and the quality of the worker-person relationships. This suggests that critical to belonging is how people are with each other. Reflecting upon the quality of the interactions with his worker, one person said, *'He has journeyed with me'*. Various interactions were also described where there was a seeking of the involvement of the person in decisions about the future. *'[The worker] wants to know what I want to do… [He says] you're in the driver's seat. Tell us where you want to go'*.

There were numerous examples of interactions that, although seemingly straightforward, did much to affirm the person's sense of their status and worth. In one instance, the worker explained and demonstrated that beneath the unclear communication and behaviour of one person who was obviously struggling with the effects of her illness, were strong attempts to reach out and to be heard. The worker was clear that the woman's voice should be heard, and sought a successful way for the researchers to connect with her.

Four people gave clear examples of being heard, and even more importantly, being believed for the first time in their lives. They expressed the immense relief this gave them, and the importance of having their experiences believed and their feelings validated. Having someone on their side cannot be underestimated in importance, especially for people who have experienced rejection and a sense of powerlessness *'I appreciate them having time for me…otherwise I'd have no one…it's really good that they're there for me"*

c) Help people to tell their own story

Another way in which workers were found to support people's sense of belonging to self is by assisting people to tell their own story. The ability to talk about ourselves and speak to our experiences is one that is often taken for granted and is a vital way in which we share

who we are and make sense of our own experiences (Bruner, 1990). Cushman (1995) says that telling and retelling a story helps a person to create a sense of self. For some of the people participating in the research their ability to tell their story had been reduced through their experiences of trauma, mental illness and the effects of medication that left holes and spaces in their history. In sharing timelines with the researchers, people often could not account for years of their lives or were unsure about the sequencing of events. This is an outcome not only of the mental illness itself, but of the many interventions in their lives including: being moved between institutions and services, the continual flow of professionals through their lives, some of the disorienting treatment approaches and medical side effects, or having only heard their own story told to them by professionals through mental health and human service jargon. Helping people to tell their story requires workers to work in multiple literacies, to listen deeply and to create spaces for people to recover their histories.

(ii)   Support 'belonging to something beyond us'

The sense of a transcendent belonging, belonging to a higher purpose or spirituality or to the cosmos was not spoken of directly by participants. This makes sense given the limited time researchers had with individuals, and the depth of relationship and sense of personal safety required to usually share those parts of our belief system with others. However what was observed was a deep respect for people's spirituality by the workers, and efforts made to assist people to find expressions for that. For example, when one woman with a deep spirituality could no longer attend bible study classes or church, efforts were made to find an ally with similar beliefs who would like to spend time with her in her own home. In addition, through the strategies used to belong to self, many people also expressed a sense of a broader connection to others and a sense of a higher purpose. One person explained,

> *'[Sharing my story] gives information and is a way of grasping community*
>
> *support. It is empowering. It is a way of making a difference and it gives me*

strength. Sharing my story helps me work towards recovery and helps others work towards their recovery. Sharing my story gets me beyond myself: it helps me work against distrust…It gives a sense of hope to myself and to others.'

(iii) Support 'belonging to others'

This research revealed three specific ways that workers can assist people to belong to and within community: finding places that are welcoming, supporting freely given relationships and offering felicity and fellowship.

a) Find places that are welcoming

Human services can strengthen and deepen people's sense of belonging by assisting the people it supports to find places in community that are more welcoming and open to their presence. One worker described this aspect of the work *as 'building relationships in places where [the person] feels welcome.'* Given that people's experiences of the world have often been one of hostility and rejection, the creation of safe and welcoming spaces is seen as vital. During transect walks through the community, several interactions with local shop keepers were witnessed where the person was not simply tolerated and served, but greeted by name and spoken to with respect and with real warmth. They were not simply a customer, but were welcomed as 'a regular'. In this case it was clear that this work occurred through the very deliberate intervention and support of the workers to find welcoming spaces.

b) Support freely given relationships

In addition to finding welcoming places, workers assisted people to feel a sense of belonging by bringing people in to their lives to offer freely given relationships. The term 'freely given relationships' is used to describe those relationships where the person without a mental illness or impairment is not paid to be there. The presence of freely given relationships is essential to a sense of belonging: that people seek to be with someone of their

own volition (even if they were intentionally invited in the first instance). Freely given relationships include family members, and friends and acquaintances. However they also include those relationships mediated by the service, where people were deliberately invited to step in to the lives of vulnerable individuals, not as a paid worker but simply as a member of community willing to offer relationship. In the present service, such people were known as 'allies' to clearly distinguish them from people in formal volunteer roles. While volunteers offer their time and skills to an organisation or cause and may be governed by organisational requirements, an ally stays firmly within the realm of citizen and the private sphere of the individual. In describing the role of the ally in his life, one person, using the metaphor cards, chose an illustration of silhouettes on a beach to depict what he described as *'being with'*. One person, who has become an ally following their student placement, joined with the person in explaining that they share an enjoyment of bikes, and that they were learning things from each other. This reflects mutuality in the relationship that takes the relationship beyond one of mere charity.

For the workers, their support role is two-fold. They identify and invite people into the relationship, and they then protect and support the relationship. One worker explained her work was less directly with the individual receiving a service and more about *'supporting his supports'*. Her efforts were focused upon ensuring the longer term sustainability of the work, by doing the background work necessary to strengthen tentative relationships. The workers were clear that *'allies trump workers'*, meaning that a freely given relationship was always given priority over human service arrangements, activities or set staff rosters.

c) Offer felicity and fellowship

A related theme to emerge was the difference made in people's lives by the presence of felicity and fellowship. Felicity here refers to the positive feeling of a service. Felicity was

related intricately to the experience of camaraderie and mutual support. Fellowship refers to the wellbeing of a collective, each member demonstrating care towards another.

The feelings of welcome and acceptance were often identified as positive features that assisted a feeling of belonging for service recipients. For some people, this feeling was definitely associated with the neighbourhood centre building where the agency is based and the activities that are held there. One person described the agency as 'like a community lounge room … where I have never had to hide my emotions. I have never been embarrassed'. She spoke positively of the environment and its informality, explaining that because the building is a neighbourhood house with a non-corporate feel *'people aren't so formal in this environment'*. Yet another explained, *'I feel comfortable there'*. There is a sense that the workers *'share and cooperate'* [with each other], which contributes to felicity. In relation to the training and discussion groups that occurred within the service, people talked about liking the *'linking up'*, *'meeting people'* and the *'talking to people'*.

People spoke of similar feelings of being made to feel welcome, and feeling relaxed at other events held by the service: conferences, meetings and workshops – even when held away from the service's premises. This suggests that the feeling of welcome and belonging created at the service office is carried into other events and activities by all people and transfers to whatever environments activities occur in.

This last strategy is a particularly complex one and it is to here that the discussion will turn.

4)   A dilemmic space: when the people say they want to belong to the agency

The conundrum is that it is likely that the more an agency builds a trustful and safe alliance with a service participant, the greater the danger of the agency itself becoming 'community' for the service participant. This is in contrast to the work of an agency that leads

the person to community life. The following identifies the research finding, and then explores the issue.

As identified above, the research found that the agency had created a welcoming and accepting tone. Further, service participants expressed a desire for group activities, bus trips and barbecues. One participant commented for example, *'[The agency] could be doing more to help build relationships <u>between</u> the people they support and to help 'the feeling of community'* [added emphasis]. She emphasised that this was not about creating peer support groups to talk about depression, but rather the provision of social opportunities and relationships between participants.

One of the most stark impressions gleaned by the conversations with service users is that a significant number are caught between two worlds. There is a world of marginalisation, entered through the doors of mental illness, poor health, poverty, and vulnerability. Then there is the 'other' world: the typical and ordinary world that most people belong to and take for granted. One person commented: *'It's nice to connect with people without mental illness. It brings me back into <u>that</u> world'* [emphasis added].

The research found competing messages. On the one hand, people seek belonging to and with people who are from the 'valued' world. Some, however, say that they want belonging to those who are also marginalised, in a space that is friendly and welcoming. There is an overwhelming dynamic that forces people to the edge of society. One person identified that there is an underbelly in our society and the ostracism leads to people being part of that underbelly. Another person explained with some relief that because of the work of the agency and because they do not now have to spend time in services for homeless people or for those in crisis, they do not *'have to be with dodgy people 'cos they're the only ones left over on the fringes of society.'* When looking at the relationship map drawn by this

person, the participant was referring to the value of spending time with the staff and allies/supporters of A Place to Belong (Anglicare, Southern Queensland) in the absence of other people with a valued status in their life.

The request for stronger relationships between people supported by the agency through shared activities and shared places presents a conundrum not just for this agency, but for any agency engaged in community building work. It is possible to extend an appreciation of why participants might express these wishes: there is a sense of 'us against the world'; come and gather as an 'us' because 'we understand'. Given a history of exclusion and rejection, and the desire for welcome and positive regard, it is easy to see why a service that offers felicity and fellowship might be an attractive substitute for people searching for their place to belong in the world. As one participant reflected, *'People will go with what they know and feel safe with'*. On the one hand, an agency might be inclined to follow the principle (and ideology) of 'choice' and do whatever it is that consumers say they want. While there might be merit in this course of action, it should not be confused with community inclusion work. Other forces for grouping people have traditionally been financial ones, however progressive services have recognised that serving people in a building located in the community is not the same as community inclusion.

This amplifies the need for constant clarification of the role and purpose of the agency with service participants. For the agency to sustain a potent inclusion agenda, it needs to ensure that agency events, group activities, leadership development opportunities and consumer participation activities remain the *means* rather than ends of its true work. Thus a significant risk is that in the context of social isolation and loneliness, having a service can take the place of having a life. A service life can never be the same as a community life. Creating service-based 'community' is potentially harmful not only for the person being

supported but also can easily corrupt the agency's mandate if that mandate is community inclusion.

Barringham (2004) wrote encouragingly, 'Working one-by-one, each of us can assist a community to have a spirit of welcoming. Any one of us can be community builders, community assisters, or community connectors ... While we cannot manufacture inclusive communities, we can search for those spaces, places and people where inclusion and connection might occur. We can ask, invite, link and create opportunities. We can affirm, encourage and sometimes just wait for the right moment. Neighbourhood streets might look empty, people may look busy and preoccupied, front-doors might appear closed, but there will be open spaces somewhere and a community connector will be someone who believes that there is energy in spite of appearances.' (p47)

Conclusion

This discussion has traversed a broad terrain of subjects: about human society, human services, mental health supports and inclusion for isolated people experiencing mental health difficulties. We have analysed the findings from one small and modest response in one corner of the globe.

As discussed in the introduction there is a growing awareness of the importance of social inclusion and of strategies that speak to this agenda. What is clear from our research is that the social inclusion agenda needs to move beyond a concentration on activity and programs as indicators of social inclusion. While these things are important, our research suggests that they do not capture the depth and complexity of people's experiences in everyday life. Most importantly, they omit the emotional and spiritual core of inclusion: namely, to feel a sense of belonging. Words and phrases such as feeling welcome, being accepted, being known, being loved, being heard, belonging with, belonging in and belonging

to; may not sit easily in the lexicon of formal policy, but could do much to guide mental health support work. Further, the research highlighted the need to be mindful that belonging to a group of similarly excluded individuals might have rationales, but should not be confused with community inclusion work.

This research provides evidence that a small group of focussed and visionary people can build a values-based response which enable some highly vulnerable people to speak of a growing sense of belonging. We have also detailed a significant risk to the work of inclusion of this agency – that it *becomes* community life for people rather than introducing them to community life.

In conclusion, there may be something prophetic or instructive in what people have said through this research. It may be that any thinking in the mental health realm about belonging, connectedness and social inclusion may become instructive - and even prophetic - for our larger social context as much as for our work in mental health. Perhaps some of the lessons might be:

- that human belonging is about connecting in deeper ways to ourselves

- that simple things (such as story sharing) can build our connections to others

- that meaning-making and spirituality are important for our human needs for transcendence and belonging to the cosmos

- that people want to belong and that there is a need to listen deeply to hear what belonging means to each individual

- that belonging is far more important than possessions and material wealth

In earlier times we may have needed iconoclasts. It has been suggested that perhaps today we need healers, enablers and facilitators who help us to be connected (Pipher 2008). Perhaps

these are some broader lessons from our research in mental health for our larger human community.

Acknowledgments

References

Armstrong, J. & Shevellar, L. (2006). Re-thinking respite. *The SRV Journal, 1*(1), 14-25.

Bacci, C. L. (2009). Analysing Policy: *What's the Problem Represented to Be?* Melbourne: Pearson.

Barringham, N. (2004). Assisting communities to be welcoming. In Community Resource Unit Inc (2004) *Like a sweet cup of tea: shared lives, neighbourhoods and communities*. 44-53. Brisbane: CRU Publications.

Barringham N. & Barringham, P. (2002). Finding People to be There: Rebuilding a sense of belonging. A Place to Belong: An Anglicare Mental Health Network. Brisbane.

Berry, C., Gerry, L., Hayward, M. & Chandler, R. (2010). Expectations and illusions: a position paper on the relationship between mental health practitioners and social exclusion. *Journal of Psychiatric and Mental Health Nursing, 17*, 411-421.

Bertram, M. (2008). What does social inclusion mean. *A life in the day*, *12*(2), 24-27.

Bruner, J. (1990). *Acts of meaning*. Cambridge Mass.: Harvard University Press.

Carling, P. (1995). *Return to Community: Building Support Systems for People with Psychiatric Disabilities.* New York: Guildford Press.

Commonwealth of Australia (2009). A Stronger, Fairer Australia: National Statement on Social Inclusion. Retrieved from: http://www.socialinclusion.gov.au/sites/www.socialinclusion.gov.au/files/publications/pdf/report_stronger_fairer_australia.pdf

Cushman, P. (1995). *Constructing the self, constructing America: A cultural history of Psychotherapy.* Reading University, UK MA: Addison-Wesley.

Flynn, R. J. & Lemay, R. A. (eds) (1999). *A Quarter-Century of Normalization and Social Role Valorization: Evolution and Impact.* Ottawa: Prescott-Russell Children's Aid Society University of Ottawa Press.

Furman, R., Collins, K., Garner, M. D., Montanaro, K. L., & Weber, G. (2009). Using social work theory for the facilitation of friendships., *Smith College Studies in Social Work, 79*(1), 17-33.

Gulcur, L., Tsemberis, S., Stefanci, M. A. & Greenwood, R.M. (2007). Community integration of adults with psychiatric disabilities and histories of homelessness. *Community Mental Health Journal, 43*(3), 211-228.

Fieldhouse, J. (2012) Mental health, social inclusion, and community development: lessons from Bristol. . *Community Development Journal, 47*(4), 571-587.

Illich, I. (1987). *Disabling professions.* The University of Michigan: M. Boyars.

Lipsky, M. (2010). *Street-Level Bureaucracy: Dilemmas of the individual in public services, 30th Anniversary Expanded Edition.* New York: Russel Sage Foundation.

Lemay, R. (2009). Deinstitutionalization of people with developmental disabilities: A review of the literature, *Canadian Journal of Community Mental Health, 28*(1), 181-194.

McKnight, J. (1995). *The careless society: Community and its counterfeits*. The University of Michigan: Basic Books.

Office of the Deputy Prime Minister (2004) *Mental health and social exclusion.* Office of the Deputy Prime Minister, London.

Pipher, M. (2008). *The shelter of each other: Rebuilding our families (2nd edition).* New York: Ballantine Books.

Repper, J. & Perkins, R. (2003). *Social inclusion and recovery*. London: Bailliere Tindall.

Salzer, M. S. & Baron, R. C. (2006). *Promoting community integration: Increasing the presence and participation of people with psychiatric and developmental disabilities in community life*. Philadelphia, PA: University of Pennsylvania Collaborative on Community Integration. Available online at www.upennrrtc.org.

Seebohm, P., Gilchrist, A. & Morris, D. (2012). Bold but balanced: How community development contributes to mental health and inclusion. *Community Development Journal, 47*(4), 473-490.

Sherwin, J. (2011). 'The desire for friendship comes quickly friendship does not': An exploration of valued roles and relationships. *The SRV Journal, 6*(2), 22-31.

United Nations (2006). *Convention on the rights of persons with disabilities.* Retrieved 28/09/2012 from http://www.un.org/disabilities/default.asp?navid=14&pid=150

Wolfensberger, W. (2012). *Advanced issues in Social Role Valorization theory*. Plantagenet ON – Canada: Valor Press.