The Potential for Community-Based Group-work to Counter the Effects of Stigma

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This article revisits the work of Wolf Wolfensberger and Gordon Allport on stigma and prejudice and describes the potential of *Psychology in the Real World* groups to provide less stigmatising forms of help.

Stigma and prejudice

Prejudice is: an aversive or hostile attitude toward a person who belongs to a group, simply because he belongs to that group, and is therefore presumed to have the objectionable qualities ascribed to that group.
(Allport, 1954, p. 7)

The work of Wolf Wolfensberger and others on social role valorisation (e.g. Wolfensberger, 1987; 1992; O'Brien, 1989) have been influential in the area of stigma and have shaped some of the philosophies and practices underpinning community-based projects that I have been involved in over the past decade which run under the umbrella term *Psychology in the Real World* (these are described later). A day with Wolf is a day where you will be taken through an exquisite analysis of the myriad of factors that lead certain people to be devalued, stigmatised and treated badly in our society. He often tracks this carefully back through historical accounts over a few hundred (sometimes thousand) years, revealing how certain human characteristics have come to be seen as 'desirable' and people who differ in some way from these norms have come to be 'negatively valued' (and usually treated badly) in our society.

Powerful groups tend to treat people who do not fit what society at that time has defined as desired norms as 'other' and start to classify them as members of a (socially devalued) group. Modern phrases such as the 'mentally ill' and 'learning disabled' might seem more acceptable than older terms such as 'fools' and 'idiots' which were used to characterise (and legally categorise) people in the past, but Wolfensberger's analyses reveal that attitudes and behaviours to people assigned to these groups have, in many ways, changed little over the years.

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In the terminology of social role valorisation such people tend to be assigned *negative deviancy roles*. For example, they might be seen, described and treated as: *not human*, *clown like*, *a threat*, or *a charitable burden*. Opportunities to take up certain roles in life available to members of socially valued groups may be subtly or brutally denied to such people – roles such as *bread winner*, *parent* or *therapist*. Members assigned to socially devalued groups often become embedded in roles such as *patient* where they receive help designated as best for them by socially valued providers of care and have limited access to opportunities to learn skills needed to take on more socially valued roles. People cast into such negative roles tend to be denied 'the good things in life' such as being an integral member of a family; having an intimate group of friends with whom one freely socialises in settings enjoyed by most people in society; working in enjoyable and decently paid jobs seen by others as valuable; and being treated as an individual.

Socially devalued people have historically been grouped together and have suffered what Wolfensberger calls 'wounds', such as: relegation to low status and low power positions (e.g. service user); branding with stigmatising labels (e.g. schizophrenic); impoverishment of relationships, which might be largely limited to relationships with paid workers who are in roles that are more highly socially valued (such as a psychologist); congregation with other branded people and separation from non-labelled people (e.g. through living in hospitals or group homes); impoverishment in terms of material resources (e.g. suffer the impacts of poverty and insults of receiving benefits where qualification for that benefit involves acceptance of devaluing labels); loss of control of major and minor decisions over what happens (e.g. institutions are inevitably run in ways that meet institutional and staff needs rather than individual needs which are so varied they cannot be met in such settings); and impoverishment of experiences (e.g. through social exclusion).

The devaluing process leads people to devalue themselves (despite exhortations from cognitive therapists not to). Some come to feel that their life has been wasted – one man who had been involved with psychiatric services for over 25 years said to me that the only point of his life seemed to be to provide work and therefore pleasure and meaning to staff that were paid to help him. When alienated and treated as alien people start to feel alien (which, as Laing (1965) showed, can become part of a person's core identity and can manifest itself in behaviours that get labelled psychotic, leading to greater labelling and stigmatisation). Some people may withdraw from life, others might become more demanding. Some may develop fantasy relationships, whilst others might display the resentment and rage felt about such processes. All of these and a myriad of other reactions can be labelled as psychiatric symptoms and can serve to fuel a stigma cycle (see Fig. 1).

Social role valorisation maintains that state-provided helping professions and institutions are often part of the problem rather than the solution. The helping professions have long histories of harming 'different' people. As many historians have revealed (for example, see Porter, 2002; Newnes, 1999) treatments in the
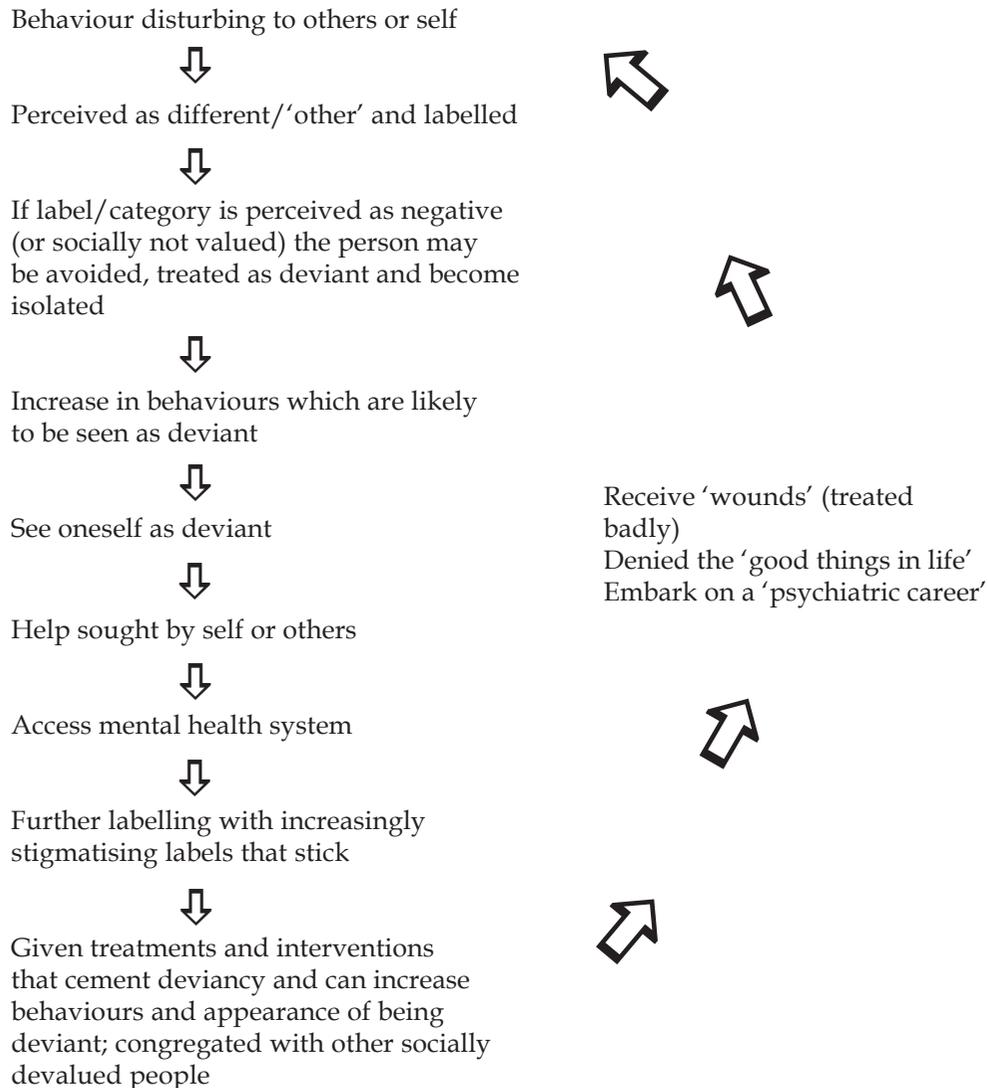
Behaviour disturbing to others or self

⇩

Perceived as different/'other' and labelled

⇩

If label/category is perceived as negative
(or socially not valued) the person may
be avoided, treated as deviant and become
isolated

⇩

Increase in behaviours which are likely
to be seen as deviant

⇩

See oneself as deviant

⇩

Receive 'wounds' (treated
badly)
Denied the 'good things in life'
Embark on a 'psychiatric career'

Help sought by self or others

⇩

Access mental health system

⇩

Further labelling with increasingly
stigmatising labels that stick

⇩

Given treatments and interventions
that cement deviancy and can increase
behaviours and appearance of being
deviant; congregated with other socially
devalued people

Fig. 1   A stigma cycle (developed from the ideas of Goffman and Wolfensberger)

past can be seen as horrific and ridiculous now: from the electrocution of black men's testicles who were suffering drapetomania – a mental illness that only affected black slaves and caused them to run away from their white masters; to the hysterectomies given to women whose hysteria was 'scientifically proven to be caused by wandering wombs'; to the mushing of vital parts of people's brains done by the Nobel prize winning pioneer of lobotomy Egon Moniz; to the electrocution of homosexual men when their penises reacted to homoerotic images presented to them by psychologists trained in behaviour therapy. But treatments today are often characterised by similarly 'heroic' attempts to change people

designated as deviant: the electrocution of elderly women in order to induce epileptic fits to treat their depression; the widespread proliferation of what psychiatrist Peter Breggin has termed 'brain disabling' medication given to people aged from four to one hundred and four; personality disorder clinics providing specialist treatments even though there is no agreement of what constitutes an 'ordered personality' or even agreement on what the term personality means; the taking away of basic human rights (such as the right to refuse damaging medical interventions) from people deemed to be a risk to themselves or others even though individual behaviour is unpredictable (beyond the aphorism 'nothing predicts behaviour like behaviour' which is not particularly helpful regarding individual risk assessment and management); and the compulsory detention of people in environments that even the clinicians involved in the detaining feel are not conducive to good mental health (such as poorly-staffed acute psychiatric services where the bureaucratic demands on nurses result in patients being continually assessed but rarely attended to, and which result in mountains of records but patients saying nothing helpful happens in the unit). Wolfensberger (1987) has written on what dangerous places health services can be for people and of the process of 'death making'. In short, services are often places people at risk of being devalued may need to avoid.

Social role valorisation advocates helping people access and engage in positive, socially valued roles. People should be helped to attain competency in those roles (e.g. by learning new skills) if they do not possess sufficient competency to presently carry them out. Its proponents advocate action at different levels, not just the personal, but also in the immediate environment of the person (where they spend their time) and in society as a whole – it is incumbent on those who really want to help that they also put great effort into bringing about political, legal and attitudinal change throughout society. Wolfensberger advocates alliances between socially valued and socially devalued people in society – such alliances can serve to unify people, broaden acceptance of differences, and encourage the coexistence of people.

There might be much in social role valorisation that is open to critique. Mad Pride and similar organizations have brilliantly countered prejudice not by having alliances with socially valued groups (people judged as 'sane') but by extolling the virtues of being mad and being different. As Peter Campbell and others have argued, alliances between different socially devalued groups (women, gay men and lesbians, black and minority ethnic groups, people with physical and learning disabilities, etc) can be helpful when trying to bring about political change and fighting for universal civil liberties (Campbell, 2001). But the analyses of social role valorisation do pose a significant challenge to all people in the helping professions to reflect on what we do. I have spent most of my career in the NHS doing research, training and consultation work with members of the helping professions that has largely focused on the harm that is done in the name of help. *Psychology in the Real World* ventures have provided opportunities to minimise and counteract some of that harm.

Psychology in the Real World groups

Psychology in the Real World is an umbrella term under which, with the support and involvement of many other people, I have set up a number of groups, courses and ventures in Shropshire since the late 1990s. Rather than bringing people together because they have a shared problem or diagnosis, *Psychology in the Real World* brings people together who have a shared interest. For example:

- *Understanding Ourselves and Others* provides people with opportunities to explore a range of theories that might help us understand various aspects of our lives (e.g. What leads us to be angry; violent; depressed? What helps people feel safe and secure? Why are we so afraid of mental illness?)

- *The Black Dog* enables people to collectively critique the concept of depression and explore a wide variety of theories and research on what leads us to become depressed (e.g. look at whether depression might be one way we react to oppression)

- *Thinking about Medication* enables wide-ranging discussions between people who take psychiatric drugs and various professionals who prescribe and help people come off medication

- *Out of the Box* helps people trying to come off psychiatric drugs to support each other during this process

- *Toxic Mental Environments* provides people with opportunities to analyse aspects of the world we live in that might be detrimental to our wellbeing, and link up with others with the aim of bringing about some changes in these environments

- *Walk and Talk* assists people who have an interest in walking along the riverside to connect with nature and connect with others in their locality

- *The Writing Group* helps those of us who feel we gain much from writing about personal experiences to meet up and share our written work

- *This is Madness* brings people together from various backgrounds (including people who identify themselves as service users, people who identify themselves as mental health professionals, and people who identify themselves as both) in order to critique mental health services and set up joint projects aimed at reducing the impacts of stigma.

Although each group is different they share some characteristics. They all occur in non-mental health settings, such as arts and education centres, libraries, along

river paths and in local pubs. People are not formally referred to the groups – the groups are open to all and are advertised locally in non-mental health settings as well as within services. When advertising the groups, attempts are made to get as broad a mix of people as possible in terms of age, class, gender, sexuality, race and, particularly, mental health service involvement. Roughly a third of participants tend to be accessing secondary services such as community mental health or assertive outreach teams, a third have had some primary care service (e.g. taken psychiatric drugs prescribed by a G.P. or received counselling) and a third have had no previous mental health service involvement. The age of participants has ranged from 4 to 84 – from a young child who regularly joined in *Walk and Talk* alongside his parents to an octogenarian who, during *Thinking about Medication,* described herself as a 'carer and psychiatric system survivor who was damaged by ECT over 30 years ago'. This mix of participants contrasts sharply with most mental health services which tend to categorise people in terms of some attribute or presenting problem and exclude people who do not fit certain criteria.

The groups are often inspired, planned and co-facilitated by people who have previously attended other *Psychology in the Real World* courses and are frequently based on ideas that came out of these groups. For example, *Toxic Mental Environments* and *Thinking about Medication* led to explorations of the importance of accessing the countryside as a way of people detoxifying reactions to contemporary culture and as an alternative to taking psychiatric drugs. This led to Anna Hughes and me setting up *Walk and Talk*. Anna, as well as being a mum and a marathon runner, describes herself as a mental health service user. *Walk and Talk* has subsequently been run and organised by a collective of people, some of whom have a history of mental health service involvement, some of whom do not, but all of whom initially came along as members of the group.

The groups are not 'skills for ills' groups – they respect the fact that, as one participant put it, 'there are as many recoveries as there are people'. There is a recognition that each person's reactions to life experiences are unique and complex, there are a myriad of causes of distress, and sharing our experiences and thoughts with others enables a collective wisdom to arise that often outweighs the wisdom of any expert (see Surowiecki, 2004). Following the lead of Paulo Freire, participants are not seen as empty vessels needing to be filled up with knowledge passed on by the group leader, but rather as people who can develop their own ways of critiquing the world that they live in and its impacts on them and others. Group members may learn *how to think* but are not taught *what to think*. As one participant put it, 'I expected to be told the answers, but this is much more liberating!'

In the groups research findings are discussed and critiqued (e.g. *What lessons might we learn from the Milgram and Stanford Prison experiments? Might the validity of research conducted by organisations that have a financial interest in obtaining positive results be sometimes compromised?*). However, unlike the NICE guidelines, the evidence of group members' lived experiences, and reflections on those

experiences, are given just as much weight as findings from 'the evidence base'. These are also held up for critique (e.g. *To what extent are insights gained from our own personal experience applicable to others?*) We explore theories and research relating to the causes of people's distress, but look beyond immediate factors to the *causes of causes,* for example aspects of 21st century consumer capitalism that perhaps damage us all. Participants are encouraged and assisted to move from critique and analysis to social action during and on ending the groups.

The groups are described in detail in *Psychology in the Real World: Community-based groupwork* (Holmes, 2010), which includes chapters by people who participated in and went on to co-facilitate *Psychology in the Real World* groups. Evaluations of the groups are available on-line (www.shropsych.org/psychologyintherealworld.htm) and in the published literature (e.g. Holmes and Gahan, 2007).

The potential for *Psychology in the Real World* to counter the risks and effects of social devaluation and stigma

> It was so good to realise that in spite of or because of all our faults and failings we are all mortal and members of the human race and it's ok not to be scared of those who live and express themselves differently.
>
> (Participant on an *Understanding Ourselves and Others* course)

Some of the people who get involved in *Psychology in the Real World* ventures have for years been involved in CMHT services that are aimed at helping 'people with severe and enduring mental health problems'; some have had periods in psychiatric hospital; some have diagnoses such as schizophrenia, manic depression and personality disorder; some until recently lived on long-stay hospital wards receiving years of rehab that were based on token economies (a recent conversation on *Walk and Talk* led to us renaming this as 'earning the right to get your fags back'). Such people are at high risk of social devaluation and stigma. Over several decades John O'Brien has looked not just at the harm services can do in these areas but has written extensively on *what is worth working for?* (see O'Brien, 1989). He identifies five closely linked service accomplishments that do not prescribe how staff working with people assigned to socially devalued groups should behave but identify outcomes worth struggling for. These are:

1. *Community presence*
   Countering the risks or effects of social devaluation involves people sharing the ordinary places and engaging in the ordinary activities that define community life, increasing the number and variety of places a person knows and can use, and avoiding segregated services that increase the process of social devaluation and the risks of being treated badly because of that process.

2. *Community participation*
    This emphasises the importance of people being part of a network of
    personal relationships that includes a variety of people not just those
    people one is congregated with as a requirement of receiving help.

3. *Having valued social roles*
    This points to the importance of engaging in activities and taking on roles
    that bring about a sense of dignity and respect, and having a place among
    a network of valued people, as well as avoiding being entrenched in low
    status activities.

4. *Making choices*
    People should have as great autonomy as possible (and much greater
    than they are often permitted) in small everyday matters (e.g. what to do)
    and large life-defining matters (e.g. who to live with).

5. *Contributing and increasing competence*
    This involves people contributing as fully as possible and skilfully
    performing meaningful activities (with training and assistance when
    required).

Psychology in the Real World: Community based groupwork (Holmes, 2010) has many
chapters, including chapters written by participants in the groups who have
long histories of involvement with psychiatric services, that detail how these
aims can be achieved. For example, people attend the groups as participants,
students, writers or walkers not as patients or clients. They come along not
because they are referred or because they are ill or needing treatment or therapy
but because they are interested in something. Participants chose to come having
seen the flyers (on notice boards in as diverse places as G.P. clinics, mental
health services, cafes, shops and pubs) rather than are referred in letters detailing
their problems and deficits or forced to attend as part of a community treatment
order. The venues are free of the stigmatising signs and messages that
characterise many mental health settings and tend to be full of people attending
courses (or drinking) rather than people who are being assessed or receiving
treatments. The groups occur in the ordinary places of life not places where
socially devalued people are congregated in order to receive help and be
efficiently processed through systems by (socially valued) professionals.
Participants are treated as autonomous individuals, as equal members of the
group whatever their background. People with long histories of involvement
with mental health services mix with people with no involvement with these
services – this not only enables community presence and participation, it lessens
stigmatising attitudes in the wider population. For example, many people who
have attended mental health services disclose this fact at some point. Participants
who have not had this experience are often surprised to discover that group

members they have got to know as people have been in the local psychiatric hospital, hear voices, have self-harmed and so on. As a consequence they can come to have some of their stereotypes and prejudices challenged.

Many *Psychology in the Real World* courses can be conceptualised as adult education. As Sue Arnold has written, by insisting that adult education became focussed on formal academic achievement the government spoiled the enjoyment many people got from learning in an environment that was freed up from the continual need to achieve and get qualifications and missed the fact that informal education provides social glue for communities as many people go on courses in order to make friends. This is often openly acknowledged by *Psychology in the Real World* participants who reveal that one reason they signed up for the course was that they were lonely. The groups offer people from all walks of life opportunities to become friends and feedback shows that this often occurs, assisted by the fact that we have breaks which enable more informal contact between people, and participants often lunch together after the main activity has taken place in the venues' cafes or in local pubs after *Walk and Talk*.

As well as making friends people on the courses have gone on to set up formal and informal groups aimed at supporting each other and other people. For example, one *Black Dog* participant set up a *Changes* group, initially with a membership made up of several people who had come on the course, but later with a much wider membership, which ran for several years with people meeting on a weekly basis. Another group member, who through attending *Psychology in the Real World* groups came to see her difficulties as relating to loss and the way people and society in general respond to bereavement (rather than being caused by depression) set up *Amongst Friends*, a friendly, informal group which has met for many years in a local café and is open to anyone who has recently been bereaved. Other group members have set up groups where people meet regularly and engage in a variety of activities that reflect the myriad of things people enjoy and find helpful.

Some members of *Psychology in the Real World* groups have later taken on a variety of socially valued roles regarding projects connected with *Psychology in the Real World*. These include: consultant and contributor to the planning of other groups and projects; group leader/facilitator; researcher; sole or co-author of articles in peer-reviewed journals; chapter writer; lecturer at universities; trainer of staff; conference presenter; campaigner; committee member on local authority committee; consultant to other people wanting to set up similar groups.

The majority of people who have taken up these roles have had long histories of involvement with psychiatric services and have suffered many of the wounds described by Wolfensberger. Some have needed help to attain specific competencies in these roles e.g. assistance preparing talks given to staff teams and at conferences (including role play preparation and support on the day); training in facilitation skills; training in research skills; editorial help regarding

writing in an academic style. I have tried to provide this as well as encouragement coupled to the minimal necessary support. In doing so I have followed Erich Fromm's maxim: *There can be no real freedom without the freedom to fail*. No-one, however, has failed in these roles. People's inner critics have often lambasted them after they have, for example, given a talk about one of the groups, but the actual feedback from listeners has tended to highlight their contribution rather than mine when it has been a joint endeavour. Some who have gone on from being a participant in a group to taking up other roles have been naturally gifted in these areas, or re-acquainted themselves with skills not utilised since perhaps having a breakdown. Others have been keen but at the outset did not appear so well suited to such roles. Yet perhaps through being relied upon, they have become reliable, and through being depended on, they have become dependable. Similarly, through being trusted and respected they have perhaps grown to trust and respect themselves. All have contributed in unique ways and I have learned much about, for example, facilitating groups from co-facilitating with people with no prior experience of this kind of work.

Whilst some people have preferred to take on these roles as a volunteer (retaining independence from the NHS Trust and a greater sense of freedom to say and do what they want e.g. be openly critical of services), many have been paid for their time and contribution. Policies in the NHS Trust have developed as a result of these contributions and a wish on behalf of Trust management to involve service users more in the running of the organisation and to pay people for their time. During early *Psychology in the Real World* ventures service user consultants were able to be paid £20 for attending meetings (e.g. to help prepare and plan new projects) but not for co-facilitating groups. Partly through the example of *Psychology in the Real World* ventures and lobbying by members and their allies, Trust policies have since been modified to include payment for running groups.

Over the last decade through *Psychology in the Real World* we have been trying to do something locally, but at the same time there have been nationwide attempts to address stigma and social inclusion. These include the National Service Framework for Mental Health (Standard 1) which stated that services should 'combat discrimination against individuals and groups with mental health problems and promote their social inclusion'. Standard 1 received comparatively little attention compared to the other standards, but the government's proposed strategy for 2010-20, *New Horizons,* emphasises the importance of reducing stigma and aims to put equality and human rights protection at the heart of its plans regarding mental health. *New Horizons* plans to ensure that mental health strategy and policy is not solely the realm of the Department of Health and to join it with other aspects of government such as the National Social Inclusion Programme. In 2004 the Deputy Prime Minister, regarding the report *Mental Health and Social Exclusion* from the Social Exclusion Unit, said: 'This report shows people with mental health problems are one of the most socially excluded groups. Too often they do not have the support they

need to participate fully in society, yet we know that employment and community activities are important in promoting both mental and physical wellbeing.' The report advocated a redesign of Health and Social Services to challenge stigma and discrimination and assist access to employment, community activities, education and training. To some extent this has been acted on regarding local mental health services (e.g. Social Inclusion and Recovery Services have replaced many Day Centres). In many ways, however, the Labour government's record regarding reducing stigma and social inequalities was poor (e.g. the 2007 Mental Health Act was inherently discriminatory; the government (rather than mental health professionals) introduced the highly stigmatising category of *Dangerous and Severe Personality Disorder* in order to be able to detain people without trial; 1997-2010 was a period of increasing social and income inequality). The British Psychological Society, which has published a discussion paper on socially inclusive practice that highlights the work of Janet Bostock in combating discrimination in the workplace, Catherine Sholl's work in schools challenging prejudice and Rufus May's work with *Evolving Minds* (a similar project to some *Psychology in the Real World* ventures) is also trying to look beyond the narrow confines of one-to-one therapies, which at best do little to combat stigma and can add to the problem hen they occur in stigmatising services. In addition, the national *Time to Change* campaign has brought various organisations in the state and voluntary sector together to try and address prejudice and have an impact on public awareness regarding discrimination towards people identified as 'mentally ill'. In 2010 this was given a high priority in our NHS Trust.

One evaluation of *Psychology in the Real World* groups specifically looked at stigma and social inclusion (see Holmes and Gahan, 2007). Based on questionnaires sent to people who had attended three *Understanding Ourselves and Others* groups in the preceding two-year period, the research indicated that members of the groups appeared to have more understanding and acceptance of people who have been diagnosed as mentally ill e.g. one person commented: *I feel a lot less fearful of people with mental health problems. I see mental health now as a scale that we are all on somewhere rather than 'them and us'.* This reduction in 'us and them' thinking seemed to apply to people who had never been involved with mental health services *and* people who had, with an ethos 'that we are all people who can and will struggle when life overwhelms us' replacing means of categorising and differentiating the well and the ill, the sane and the mad, the depressed and the clinically depressed, which can be seen as a core part of the stigmatising process. This fits with an ideological belief that commonly permeates many *Psychology in the Real World* ventures: if we all see each other as part of the human race then categorisations such as these will lose their power and prejudice against people who have been assigned to socially devalued groups such as the 'mentally ill' may lessen. The groups are aimed at helping us notice similarities between people whilst accepting individual differences, and seeing those differences as characteristic of the individual not general

characteristics that are emblematic and symptomatic of a socially devalued group they might have been assigned to. This fits with research conducted by Gordon Allport whose *contact hypothesis* stated that prejudice can be lessened by people who have prejudiced views about each other meeting together in groups where four conditions are present: mutual interdependence; a common goal; equal status of group members; and social norms that promote equality (Allport, 1954). Facilitators of *Psychology in the Real World* groups work hard to bring about norms and group cultures that mirror these conditions (see Holmes, 2010).

If one takes Wolfensberger's critique seriously one would accept that services are part of the problem regarding stigma and would want to be wary about bringing new people into such services. Evaluations have indicated that, unlike many mental health promotion schemes which inadvertently advertise the wares of mental health services and attract more people to them, *Psychology in the Real World* courses do not bring people into the services and assist some people to have less contact with them. For example, in the Holmes and Gahan (2007) study 13% of respondents reported having had less contact with NHS and Social Services since doing the course, with none having more contact.

It is important, however, not to over-emphasise the impacts of *Psychology in the Real World* groups. In the evaluation cited above people were asked if, as a result of coming on the course, they 'felt a greater part of a community or group': 39% responded 'Yes' but 43% 'No' (18% either did not answer or answered 'not relevant'). Comments included: '*It certainly helped to be part of a group of people who were understanding and accepting, and that helped me to go on to a group where there was a greater mix of people and experiences*'; '*I feel I can join in groups more – before I felt rather hesitant and felt I shouldn't – that perhaps I wasn't wanted (pathetic but true)*'. However, other participants pointed out the transitory nature of this sense of belonging: '*Not as a permanent state. Whilst the course ran there was a group member feeling*'. Similarly, only a minority reported feeling less lonely (26%). Although some people said they never feel lonely, others said they always feel lonely or alone whatever the circumstances e.g. '*I always feel lonely. No amount of interaction will change this. It is the way I am and always have been*'. Such modest changes indicates the size of the task when trying to reduce loneliness, isolation and stigma and increase social inclusion.

Concluding thoughts

Mental Health services (Wolfensberger would say by their very nature) have a poor record in this area but there is scope to move from labelling, congregating and treating the mentally ill (and thus inevitably contributing to the devaluing process) to primarily focussing on reducing the amount we, as service providers, stigmatise people and enabling access to activities in 'the ordinary places of life' that help people and repair rather than inflict such wounds. It is important that this should be driven by ideology and evidence of what works best for local people, though, and not be used as justifications by managers given the

unenviable job of reducing costs and cutting services. And whilst some of these ideas seem to be gaining ground in mental health services and even becoming mainstream (e.g. regarding *New Horizons* and the rise of Social Inclusion and Recovery Services as replacements for Day Services) the NHS seems increasingly to be dominated by managerialism and risk-averse policy-making, characterised by targets, performance management, top-down governance and computerised audit, all of which have little flexibility and most of which utilise language and systems which automatically stigmatise people who enter such systems. If the government is really serious about combating stigma (and other core themes of *New Horizons*, such as prevention and early intervention), and is serious about cross departmental action in these areas, then it is also going to have to revisit the whole way that services are currently contracted and paid for. For example, contracts based on individual contacts between expert professionals and people recorded as mentally ill do not fit with *Psychology in the Real World* philosophies and practices. Perhaps the government and various stakeholders (e.g. commissioners) just need to trust clinicians to provide anonymised numbers of the people whom they have had contact with as a measure of 'activity', knowing that to falsify this constitutes fraud. Given the long history of categorisation, separation and experimentation on people differentiated as mentally ill (see Foucault, 2001), the top-down control governments exert on how money is spent, the covert privatisation of healthcare, and interests of the psy-industry being well-served by the concept of individual treatments for individual problems, this may be a long-time coming. In the meantime perhaps more of us can try and think and practice 'out of the box' and get involved in the types of projects described above.
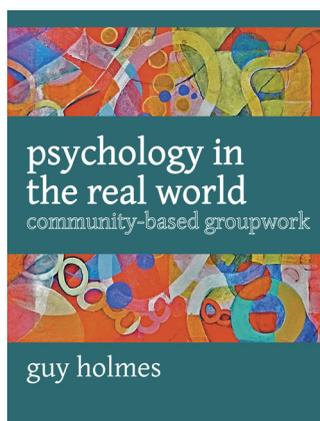
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