

CAN REHABILITATION PREVENT SOCIAL EXCLUSION?

by

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It is very interesting within the framework of the Summit for Development organized by the UN, to open a space of specialized discussion, in which occupational therapists or ergo therapists can debate how rehabilitation is linked to the social phenomena.

With regards to the question on the possibility of preventing social exclusion through rehabilitation, I will try to describe some points of view, linking this presentation to Chilean reality and in particular to my experience in recent years: occupational therapy in the area of mental health and human rights.

Firstly, the question tends to imply viewing rehabilitation as a phenomenon independent from the social reality, when it really is an expression of the same phenomenon that, nevertheless, is not found in the same level of analysis.

Rehabilitation is a very specific stage of the different actions that are carried out in health. Its expression is essentially given in the tertiary level of care, either at the community level, intermediate or hospital. Therefore, it is part of a general therapeutic process which attempt to resolve mental health problems.

Mental health is an integral part of the health-disease process, if this is seen as a continuum that presents two extremes and in which line different problems express themselves. The traditional medical perspective views the health-disease process as an expression of biological phenomena, independent of the historical context and the concrete reality of the person. This approach is clearly insufficient for understanding rehabilitation as a social phenomenon and to answer the aforementioned question.

On the other hand, if we perceive the health-disease process as an expression of the individual as a whole, health, disease or death will be understood as a result of the life that this

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individual is carrying out in a concrete society and in a specific historical moment. Seen this way, all of the areas related to the health-disease process, that is, both the pathology and the curative actions and public health, have their origin in the social structure and are conditioned, therefore, by the social life that is generated within the framework of socio-economic structures.

If rehabilitation emanates from the social, we will be able to answer the question posed, not from rehabilitation itself, but from the social ambit.

In the field that interests us, it is undeniable that the Governments conception of health policies is crucial to their different expressions: preventive, curative or rehabilitation, carried out at the community or hospital level. The amounts and nature of economic resources, technical and professional, infrastructure, etc. available to carry out concrete initiatives such as rehabilitation, depend on the Governments health policies. In the case of mental health and psychiatry, health policies take into account, in addition to a conception of treatment, a vision or ideology of what is socially considered to be the pathology of mental health.

In Chile, since the beginning of the century, the development of health policies has coincided with social transformations. Asylum psychiatry, repressive, based on the paradigm of madness and explained in terms of the biological and the supernatural, was followed by a psychiatric practice based on social sciences -sociology, anthropology and psychology-, which had as its aim the integration of the individual into the community, for which a rehabilitation process was required. Rehabilitation was conceived as a technical resource of health care to achieve the full integration of the individual into social life.

With the establishment and development of successive regimes with increased social awareness and more peoples participation - which attained its maximum expression during the government of Salvador Allende - the potential of health policies was demonstrated by working with the community and the role of rehabilitation as an indispensable factor in shifting the patient from the hospital to a natural social setting was consolidated.

Rehabilitation' s connection to the social process was demonstrated once more, with the serious reverses suffered by health care during the military dictatorship. During this period, psychiatric hospitals became the instruments of the policies of repression. This effected treatment techniques, and rehabilitation no longer fulfilled its objective. It was transformed into a series of functional activities that had little to do with the social insertion of individuals. During this period, psychiatric practice was once again strictly biological, fundamentally related to asylums, with an oversized burden of assistance. The supremacy of the principle of the subsidiary role of the State, of financial self-sufficiency in health care as well as in education, the concept that the State no longer

had the duty to provide health care, the view of health care as a commodity, all contributed to a drastic reduction in resources for rehabilitation. The result of this was a revolving door for patients who were constantly in and out of the hospital.

Unquestionably, rehabilitation is dependent on the social situation. Essentially, in its theoretic and practical basis, rehabilitation should have as its final aim, placing individuals in the community in roles equivalent to those of persons who are not diseased or handicapped. Its goal is to make someone who has suffered an infirmity a legitimate part of society, and the driving force behind its actions is to avoid exclusion. However, in order to effectively integrate the individual into the community in a protagonistic role, that is carrying out a productive social function that makes them legitimate members of society, it is essential that rehabilitation takes place in a social context that promotes insertion rather than exclusion.

Whether and to what degree this can be achieved depends on the form of organization that the society offers to confront the problems of health and disease, on how professionals and technicians are trained and structured, on how economic resources and infrastructure conditions are generated and how they relate to each other and participate with society in this task.

A society sustained by solidarity and human rights will have better conditions for rehabilitation to comply with its fundamental objectives. In this kind of social context, rehabilitation oriented toward social insertion as a concrete way to prevent exclusion, should meet some basic conditions when it is carried out: it should always be viewed as a multi-staged process, with a beginning and an end, including evaluation and follow-up; it should be intensive and planned, considering the whole person, from the medical, biological, psychological, familiar and psycho social aspects; it should include the use of drugs, involve the family in the rehabilitation process, and make use of occupational therapy or ergo therapy as a substantial part of this process; its focus should be communitarian and it is essential that it be carried out by a coherent inter and multi disciplinary technical team which has concordant theories and methodologies. It should promote the development of a general framework of abilities which affirm the identity of the individual, which support the individuals vital process of change, accentuating the individual' s strengths, and helping them to regain their ability to be active and productive, if possible with the aim of participation in the job market.

With this perspective, rehabilitation can be defined as a form of health care which attempts to lessen the handicaps produced by disease, recuperating social function as much as possible by training techniques and the development of skills and coping abilities, with the fundamental hope that the person can go on with their lives and with an increased level of social activity, making them in charge of their own process of change. But an inclusive social context that respects personal dignity

is necessary for this to succeed.

The big question then, is if rehabilitation can prevent social exclusion given the present historical conditions.

It is doubtful that rehabilitation can complete its objectives in the present model of neoliberal capitalist development. A society based on the market, on free competition, on consumption and gain, on the accumulation of wealth on the part of a minority at the expense of the majority, will necessarily reflect the consequences of that model in every plane of social development. It will be a society that is in essence exclusive and that violates individual equality and that makes the ones with the most economic resources the ones with the greatest possibility for social integration.

In the case of health, this is expressed by forcing the health services to be financially self-sufficient, and by making health care into a lucrative endeavor. In this context, rehabilitation can do little, since carrying it out requires a large investment in resources and infrastructure that can not be provided by this model. Rehabilitation is a long term process and has a cost that most patients are not able to assume economically. Not only that, but insertion without exclusion requires intermediate situation such as protected workshops, which because of their high costs, have hardly been developed in our country. Those that do exist are mostly private and are used to generate income as if they were a business.

There are some patients who are the object of rehabilitation, from my point of view, who have been functionally integrated into the social setting, but this does not mean that their incorporation is without discrimination. My experience in the past years has shown that a great number of these patients who may have gotten a job don't receive the same treatment, rights and benefits as another worker who has not been seriously ill. The stigmatization continues and it is expressed in unequal wages and jobs with lower social value.

Exclusion in the current social system in my country is more dramatic in the case of victims of political repression. The primary concern of CINTRAS has always been people who directly experienced the repercussions of State terrorism. Therapeutic programs, in which rehabilitation plays an important role, have not been able to overcome the social exclusion of the people who are the objects of our practice. They have been abused, stigmatized, under-valued and repressed. Their exclusion and the lack of true incorporation for these persons in the social framework has been consolidated in the present social context, whose political-juridical structure is largely unchanged from that of the military dictatorship.

There are no global policies on the part of the State to re vindicate the social being of our patients, nor are there any programs of assistance for their social re-insertion.

The strategy of rehabilitation that we have designed in occupational therapy at CINTRAS is based on organized, systematic teamwork. It utilizes a wide range of technical resources and treatments, including individual and group therapy, therapeutic workshops, ergo therapy and occupational therapy, and psychotherapeutic activities. It does crisis intervention, works with families, and provides evaluation, orientation, training, job placement, etc.

We have had encouraging results in terms of symptomatic improvements, in partial recuperation from psycho social damage, in developing coping skills and abilities, in re-building personal lives, in empowering people to be agents for their own change and to generate their own social and historical reality. However, since the problems of mental health derived from political repression are eminently a social phenomenon, originating in the contradictions in the economic base of the society, recuperation from damage can not be complete without basic changes that are expressed in the true democratization of our society, in terms of impunity and the permanent respect for human rights.

While these conditions are not met, the rehabilitation that we have carried out with our patients, which is demonstrated by a great many of them who have succeeded in joining the workforce and society, still cannot overcome the exclusion which they continue to feel. In these cases, it is clear that although they have gone through an adequate rehabilitation process, this does not keep them from experiencing the social exclusion imposed by the social-political context.

So, to return to the original question, “ Can rehabilitation prevent social exclusion?” we have to say that our experience leads us to conclude rehabilitation in and of itself, even if it has an appropriate working group, and adequate economic resources, and defined methodology, techniques and objectives, can not reach its fundamental goal if the social context in which it is carried out is not in essence a setting that promotes integration, solidarity and respect for human rights.

Therefore, our job as professionals is not just to continue the mere technical-clinical tasks. Along with collaborating so that the patient takes an active role in their own social inclusion, we also must overcome the frontiers of therapeutic technicalism, and become active protagonists for social change that is needed so the rehabilitation we develop can effectively comply with the objective of overcoming the social exclusion of the people we rehabilitate.