editorials

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Social inclusion and mental health

The Government's commitment to reducing social exclusion, through concerted action across departments, has rapidly led to some specific changes in both policy and implementation. For example, in 1999 the Social Exclusion Unit examined the problem of young people who were neither in work nor education. They found that this group made up 9% of 16–18-year-olds and was served by a fragmented and patchy support system. They recommended a new more integrated 'personal advisor' approach to tackle interlocking issues such as school exclusion, literacy and numeracy problems, ill-health, young parenthood and joblessness (Social Exclusion Unit, 1999). Within less than 1 year the first pilots of their proposed Connexions Service has come into place (April 2000), with nationwide implementation to follow from 2001.

There has, as yet, been no comparable Social Exclusion Unit report heralding rapid progress to increase inclusion for people with mental health problems — although the unit's life has been extended to 2002, so the potential remains. But significant opportunities also exist through broader initiatives, notably the new Disability Rights Commission and the Mental Health National Service Framework.

The relationship between social exclusion and mental ill-health is complex, with many of the elements of 'exclusion' (low income, lack of social networks, joblessness) being in different circumstances both causal factors and consequences of mental ill-health (Brown & Harris, 1978; Jahoda, 1979; Link *et al*, 1997; Perkins & Repper, 1996; Department of Health, 1999; Sartorius, 2000; Sayce, 2000). Initiatives generated by the Social Exclusion Unit may prove to have some significance in terms of prevention. For example, if the Connexions Service was to succeed in reducing the numbers of young people who are poor, unskilled, jobless, disaffected, lonely, without hope and bringing up children alone, this might impact on rates of depression in these groups (Brown & Harris, 1978).

However, it is a truism to state that people actually diagnosed with a significant mental illness are among the most 'excluded' in society (Sayce & Measey, 1999; Sayce & Morris, 1999; Sayce, 2000). At best 15% of working age people with long-term mental health problems are working, far lower than any other group of disabled

people (Labour Force Survey, 1999); and joblessness and lack of social networks are often exacerbated by discrimination and profound loss of social status (O'Donoghue, 1994; Sayce, 2000). All these aspects of 'exclusion' increase disability (Wing & Morris, 1981; Perkins & Repper, 1996; Sartorius, 2000) and impede recovery. Deegan has eloquently described the 'recovery' (not cure) that is possible for someone with long term psychiatric disability, through determining and pursuing a fulfilling life in changed circumstances. This requires that a range of social and economic opportunities are actually available, as well as choices of treatment and support (Deegan, 1994).

Social inclusion is an imperative both as a rights issue, in terms of changing a pattern of massive social and economic exclusion, and in relation to the goals of therapeutic practice.

If social inclusion is to be given greater impetus in mental policy and practice, leadership is required from psychiatry and the other major mental health professions as well as the user movement.

From exclusion to inclusion: a legitimate goal?

The Social Exclusion Unit defines social exclusion as a combination of interconnecting factors including low income, poor housing, low skills and poor education. But the word 'exclusion' means more than mere economic disadvantage. Duffy (1995) talks of

> "A broader concept than poverty, encompassing not only low material means but the inability to participate effectively in economic, social, political and cultural life, and in some characterisations, alienation and distance from the mainstream society."

The latter conceptualisation is highly relevant to the experience of mental health service users. Research and consultations with users repeatedly reveal that while, for them, one major priority is reducing poverty, they also identify the desire for a role (or roles), for more friends and relationships, for less rejections by neighbours, employers and family and more opportunities to be part of mainstream groups and communities (Read & Baker, 1996; Mind, 1999; Sayce, 2000). This suggests that social exclusion and inclusion are potentially powerful concepts

121

in relation to service users' experiences – more powerful than 'poverty' or 'inequality' alone.

We can conceptualise social exclusion in relation to mental health service users specifically as the interlocking and mutually compounding problems of impairment, discrimination, diminished social role, lack of economic and social participation and disability. Among the factors at play are lack of status, joblessness, lack of opportunities to establish a family, small or non-existent social networks, compounding race or other discriminations, repeated rejection and consequent restriction of hope and expectation.

Inclusion may be defined in terms of a virtuous circle of improved rights of access to the social and economic world, new opportunities, recovery of status and meaning and reduced impact of disability. Key issues will be availability of a range of opportunities that users can choose to pursue, with support or adjustments where necessary; for example, education, work, joining social, cultural and religious groups, friendships and relationships, raising a family and participating in civic life (jury service, voting, political office).

Of course the whole concept of social exclusion has been criticised, perhaps most memorably by a group of 54 Professors of Social Policy, who in 1997 argued that the identification of a defined excluded group 'erased from the map' the broader issue of income inequality across the social spectrum (open letter to the *Guardian*, 14 November 1997). In the health sector the goal of 'inclusion' has also been critiqued for its implication that social cohesion, rather than political change, is the major determinant of health (Muntaner & Lynch, 1999). The concept is also open to much difference of interpretation and may therefore lack robustness. However, working definitions can be constructed that do centrally address issues of power and inequality and that propose changes that go beyond enhancement of 'social capital' alone. These definitions appear to have more explanatory value in relation to the experiences of mental health service users than do 'poverty' or 'inequality' alone.

Opportunities for inclusion for service users

Mental health practice is currently driven by the National Service Framework, the first standard of which requires action to reduce discrimination and social exclusion (as well as to improve the mental health of the population). Psychiatrists and other mental health professionals can build 'social inclusion' into clinical practice, by including in care plans users' aspirations for work, education, relationships and other chosen journeys of 'recovery'.

Psychiatrists are also in a prime position to engage in the wider debates about rights. Here the National Service Framework is less significant than the Disability Discrimination Act (1995) and the establishment of the new Disability Rights Commission (DRC).

The Disability Rights Commission started work in April 2000, with a goal of 'a society where all people with disabilities can participate fully as equal citizens'. 'All' people with disabilities explicitly includes people with

mental health problems: indeed the first legal case supported by the Disability Rights Commission concerned a senior accountant with depression (Kapadia *v* London Borough of Lambeth, 2000); and other Disability Discrimination Act cases have set important precedents for people with mental health problems. For example, when Mr Watkiss had his senior job offer withdrawn because his history of suffering from schizophrenia came to light, he was awarded a substantial financial settlement and the company admitted unlawful discrimination.

The Disability Rights Commission provides information and advice to people with disabilities, businesses and service providers; helps people with disabilities secure their rights; prepares statutory codes of practice; advises Government; and will undertake formal investigations – either when there is cause for concern about a specific organisation or sector, or in order to find out what is happening in a particular sector. For the first time mental health service users will have access to an enforcement body, and organisations could be open to scrutiny if they are suspected of discriminating on mental health grounds.

The Commission was preceded by a Ministerially chaired Disability Rights Task Force (1997–1999), which gave mental health issues a considerable profile. It recommended a review of definitions of capacities (under the Disability Discrimination Act 1995) to ensure "comprehensive and appropriate coverage of people with mental health problems" (Department for Education and Employment, 1999). The Task Force's final report talks not just of tackling people with disabilities' problem of being treated with pity and charity, but explicitly cites the way that people with a diagnosis of schizophrenia are feared and demonised. It quotes, almost certainly for the first time in a Government document, the key research showing that, contrary to public perception, the proportion of homicides committed by people with mental disorders has fallen steadily in the past 40 years (Taylor & Gunn 1999). It includes vivid examples of the discrimination that mental health service users face – for example, standardised mortality ratios far higher than the average, harassment and verbal abuse. And it gives detailed examples of good practice, like the South West London and St George's Mental Health Trust User Employment Programme, which demonstrates that supporting users to work in an NHS trust brings health and social gains as well as overall savings to the public purse. It also achieves sickness absences among users supported to work (at 3.9%) that are lower than for the trust's care staff in general (5.8%) (Department for Education and Employment, 1999).

As the Commission builds its detailed policy and provides advice and guidance for people with disabilities, employers, service providers, Government and other stakeholders, it will need expert input on mental health issues. Equally, service users will need information and support if they are to seize the opportunities provided by the Disability Rights Commission, so that the discrimination that pervades their lives can gradually be eroded.

The profession of psychiatry can and should take a lead in the implementation of both the National Service

Framework Standard 1 and the disability rights agenda, by:

(a) contributing to national debates about the most appropriate definitions of disability, and capacities, in relation to individuals with mental health problems

(b) providing expert opinion and research evidence on discrimination and its impact on health and well-being (see Sayce & Measey, 1999)

(c) ensuring that 'social inclusion' is a focus of service development, teaching and training

(d) minimising the development of exclusion among those first entering psychiatric services, for example, by specifically assessing and maintaining their employment, education and social networks

(e) contributing to improvements in the assessments provided by general practitioners and occupational health physicians, on the capacity of people with mental health problems to work

(f) informing service users about their new rights and opportunities, since the inception of the Disability Rights Commission

(g) supporting service users in deciding whether and how to challenge discrimination in their lives, for example, they may need space and support to think through the pros and cons of being open about their condition, if this is the only way to seek redress or to secure a reasonable adjustment at work

(h) researching, and publishing on, the impact of initiatives to enhance social inclusion. This is crucial to ensuring that the aim in the First Standard of the National Standard of the National Service Framework, to "combat discrimination against individuals and groups with mental health problems, and promote their social inclusion", is rooted in a growing evidence base

(i) using their position of influence and expertise to counter popular stereotypical interpretations of gross diagnostic categories, through providing detailed understanding of the individual implications of conditions. This is relevant at a number of different levels: for example, in assisting a person to get work, or giving evidence in the judicial system, or contributing to media debates.

At the 1999 annual meeting of the Rehabilitation and Community Care Section of the College, evidence presented by Grove affirmed the greater effectiveness of supported open employment over any forms of pre-work training, sheltered provision or simple day care. A lively debate ensued on the potential value of the term 'recovery' as an organising principle for services for people with long-term mental health problems, where recovery refers not to removal of symptoms, but to finding meaning and purpose in a life that is changed by long-term or intermittent disability (Prior, 2000; Sayce & Perkins, 2000).

Conclusion

The time is ripe for concerted service developments that contribute to inclusion. Psychiatry is in a prime position to contribute to opportunities for service users for work, education and social participation: in short, social inclusion, not 'treatment' or 'care' alone. This means identifying 'recovery' and 'social inclusion' as explicit goals, and taking the opportunity of policy initiatives both within and outside the mental health arena to work for the reduction of discrimination against service users. The complementary concepts of inclusion and recovery, and their application to mental health practice, provide a significant new basis for common ground between psychiatrists, other mental health professionals and service users.

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editorials

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