Epidemiology and Psychiatric Sciences (2013), **22**, 43–45.
doi:10.1017/S2045796012000595

COMMENTARY

Social integration and human rights: a view from a low- and middle-income context

Received 26 April 2012; Accepted 3 May 2012; First published online 26 October 2012

Key words: Social integration, low- and middle-income countries (LAMIC), mental health gap, capabilities approach, human rights.

Commentary on: Baumgartner JN, Susser E (2012). 'Social integration in global mental health: what is it and how can it be measured?' *Epidemiology and Psychiatric Sciences* (doi:10.1017/S2045796012000303).

The systematic alienation and social exclusion of individuals with mental disorders is a major challenge in global mental health care. This phenomenon has deep historical roots and is geographically widespread to the extent that one would not be mistaken for concluding that the fundamental denial of human rights for those suffering mental disorders is a basic feature of human society. The fact that this is a globally entrenched obstacle to realizing freedom and full social integration for people with mental disorders means that we necessarily must adopt a global perspective in seeking solutions. A global mental health approach to social integration is therefore appropriate and Baumgartner and Susser are to be commended for adopting such an approach in their efforts to conceptualize the meaning of social integration and to consider appropriate means of measuring it.

In this commentary, I wish to consider three fundamental questions emerging from the special article. Specifically, I will address these questions from a developing or low- and middle-income country (LAMIC) perspective. Increasingly, the LAMIC context and perspective are recognized as not only important but also critical to realizing the common objectives of advancing mental health care delivery across the world. Global surveys and reports document the significant mental health 'gap' that exists between burden of mental disorders and scarcity of services and resources that typify LAMIC contexts (Kohn *et al.* 2004; Saxena *et al.* 2007). A large body of research highlights the importance of social, economic, political and cultural differences in how mental disorders manifest and how they should be managed. This means that concepts such as 'recovery', 'rehabilitation' and 'integration', which have been scrutinized and debated for decades in high-income countries (HICs), need to be reconceptualized within the LAMIC context if they are to have any meaning and are to impact on health services policy and planning in these countries.

Thus, if we are to consider the 'grand challenge' (Collins *et al.* 2011) of social integration of individuals with mental disorders from a global perspective, we need to grapple with the following questions: what does 'social integration' mean within the LAMIC context? What are the specific barriers created by the LAMIC context to achieving social integration in these regions of the world? And how do we best contextualize methods of measuring social integration within LAMICs?

Baumgartner and Susser discuss four frameworks for conceptualizing social integration at the individual level and in all four, social participation appears to lie at the heart of the definition of this concept. Thus, if one is participating fully and freely then one is by definition integrated. I am not sure this is the complete story though. Mere participation does not necessarily imply full freedom, security, acceptance, absence of discrimination and a sense of well-being and belonging. Wong and Solomon's framework attempts to recognize the various aspects of community integration by distinguishing mere physical participation from the ability to engage in social interactions and to feel a part of that social network or community (i.e. to have a sense of belonging) (Wong & Solomon, 2002).

This emphasis on social participation assumes a great deal and emerges, I believe, from a particular Euro-American understanding of what constitutes human freedom. It is a view that is not necessarily wrong; but in adopting a global mental health stance on social integration, it is important to acknowledge that the roots of this concept lie deep within the liberal traditions of human rights, social justice and individual self-realization. One cannot assume that the same priority is given to social integration in societies that

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have emerged outside the dominant Eurocentric regions of the world.

For example, in Southern Africa there is a proverb, *umuntu ngumuntu ngabantu* – a person depends on persons to be a person – from which derives the concept of *ubuntu*. Desmond Tutu, the South African human rights champion, explains *ubuntu* as follows: 'It is to say, 'My humanity is caught up, is inextricably bound up, in yours' … It says: 'I am human because I belong. I participate, I share' … A person with *ubuntu* has a proper self-assurance that comes from knowing that he/she belongs in a greater whole and is diminished when others are humiliated or diminished …' (Tutu, 1999). Thus, within the traditions of Southern Africa, we encounter a great value and importance given to social integration and acceptance. However, this does not necessarily mean 'participation' in the sense that it is understood in Eurocentric societies. As in traditional Zulu practice, for example, a person can feel accepted and socially integrated without necessarily participating. There are roles and hierarchies that determine levels and circumstances for participation or non-participation. For example, in polygamous households, a 3rd or 4th wife will be excluded from certain decisions and societal involvements. What would be considered social exclusion in Europe and North America is not necessarily considered non-participation or non-integration in this tradition. Playing an active participatory role is not considered a necessary element of *ubuntu*.

What does this mean for our grand challenge of promoting and measuring social integration of people with mental disorders across geographical and sociocultural contexts? And more broadly, what are the implications for a global mental health movement that is committed to ensuring human rights and social justice for those with mental disorders across the world? I would suggest that it cautions us to be sensitive to varying cultural notions and understandings of social integration and recovery. Simple participation appears to be too coarse and perhaps too unreliable an indicator of social integration. Furthermore, individuals may choose not to participate and yet have a healthy sense of belonging and social acceptance.

So, are there core elements of social integration that can be considered universal, irrespective of culture, social norms, religion and tradition? Are there basic elements or indicators that can form the framework around which local, contextually appropriate tools can be developed for measuring social integration of those with mental disorders? It seems there may be. In their discussion of social integration, Ware *et al.* (2007) consider different ways in which individuals recovering from mental disorders choose to 'reconnect' with society. They stress that there are multiple ways of reconnecting – not one prescribed path – and, as Hopper (2007) phrases it, 'however actualized, it means constructing ways of belonging and reclaiming moral agency.' The two key elements here are (a) a sense of belonging and (b) having moral agency. In other words, people should feel that they fit in and are accepted, and they should have the freedom to choose how they wish to integrate.

This brings us to the capabilities approach of Amartya Sen, Martha Nussbaum and others. Because if moral agency and the right to choose is a key feature of social integration, then this means that the opportunities must exist for exercising one's choices. A capabilities approach entails individuals having both the personal capacity or competency and the social opportunity to realize basic freedoms of life such as being safe, having health, having a livelihood, being happy and fulfilled and having a sense of social belonging. More importantly, individuals may choose not to have particular outcomes – for example a person may choose to be a recluse or live a 'life of poverty.' The capabilities approach does not dictate that individuals recovering from mental disorders should reintegrate and participate – it states that such individuals should have the right to choose this outcome if they so wish.

From the perspective of LAMICs where resources are few, legislation is often discriminatory and socioeconomic opportunities are limited, even for those who are mentally healthy, the capabilities approach is particularly relevant and attractive. The lack of resources, outdated (or un-implementable) legislation, high rates of poverty, inequality and unemployment, and widespread mental health illiteracy that characterize most LAMICs, all contribute to reducing opportunities and diminishing personal agency in those with mental disorders (Burns, 2011). Numerous barriers to accessing social and economic opportunities exist in such contexts. In his seminal work, *Recovery from Schizophrenia – Psychiatry and Political Economy*, Warner argues that opportunities for reintegration into work roles are better for those with psychiatric disorders in non-industrial contexts (Warner, 1985). This may have been the case in the past, but rapid urbanization and industrialization in LAMIC regions such as Southern Africa have led to a situation where marginalization and exclusion of the mentally ill is the norm. Opportunities for social and occupational integration in such contexts are almost non-existent. Furthermore, poor access to treatment and to evidence-based rehabilitation interventions means that individuals with psychiatric disorders are unlikely to regain personal capacities and competencies that are necessary to gain re-entry to social and occupational roles. In such environments therefore competencies are undermined and opportunities are withheld.

I believe this is a human rights issue that merits a human rights response (Burns, 2009). A global mental health approach to social integration in LAMIC contexts requires us to address the social, economic, cultural and political determinants that increase risk for and retard recovery from mental disorders.

Conflict of Interest

None

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