Position Statement

Mental Health
and Social Inclusion

*Making Psychiatry and Mental Health
Services Fit for the 21st Century*

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Royal College of Psychiatrists
Social Inclusion Scoping Group

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Preface

This position statement has been produced by the Social Inclusion Scoping Group of the Royal College of Psychiatrists. The Scoping Group was set up to examine the nature and extent of social exclusion among people with mental health problems and those with intellectual disabilities[1] and the implications for the organisation, structure and culture of future mental health and intellectual disability services and the future practice and training of psychiatrists.

The social exclusion of many people with mental health problems remains a blight on a considerable number of citizens in our society. The Scoping Group has examined the ways in which this blight is manifest. It has identified why action must be taken and why psychiatrists should be at the forefront of these initiatives. Psychiatrists are in a key position to champion the cause of service users and to ensure that they are empowered to participate.

Included in the Scoping Group's review was the full range of people with different diagnoses represented by the subspecialties within the Royal College of Psychiatrists, including those with intellectual disabilities, people with drug and alcohol problems, children and adolescents, older adults and offenders with mental disorders. In addition, people who have combinations of diagnoses such as psychotic or non-psychotic mental illness, alcohol or drug dependence, intellectual disability, personality disorder and adult neurodevelopmental disorders (Asperger syndrome, autism, attention-deficit hyperactivity disorder) are all included. The review also covered the full range of age groups and social identities – women, people from Black and other minority ethnic groups, lesbian, gay and bisexual people, and faith groups. Most of these groups are represented by the various faculties, sections and special interest groups of the Royal College of Psychiatrists and they parallel many groups covered in the Equalities Review.[2] In addition, specific groups, including the homeless, refugees and asylum seekers with mental health problems were highlighted in the Scoping Group's review as they are, by the nature of their circumstances, excluded by society.

[1] Intellectual disability is not in itself a mental health problem. People with intellectual disabilities do, however, have increased rates of mental illness, behaviour disorders and pervasive developmental disorders. In these circumstances they are doubly disadvantaged in terms of stigma, exclusion and discrimination, as a result of both their intellectual disability and their other problems. Throughout this document it is assumed that these aspects, both of the mental/behavioural disorders and the intellectual disability, are integral to the considerations therein. Note also that the term 'intellectual disability' has been used throughout, although 'learning disability' is still current within some UK health services.

[2] Equalities Review. *Fairness and Freedom: The Final Report of the Equalities Review*. Equalities Review, 2007 (http://archive.cabinetoffice.gov.uk/equalitiesreview/publications.html).

The aspiration for the Scoping Group was borrowed from the Equalities Review: we wish 'to live in a society which provides for each individual to realise his or her own potential to the fullest'. We have been committed to seeing that this aspiration applies to people with mental health problems and those with intellectual disabilities; we have therefore examined how it can inform our view of approaches to mental health services in the 21st century.

Associated with social inclusion are the concepts of recovery. The Royal College of Psychiatrists has already given explicit support to recovery in an important position paper, *A Common Purpose*.[3] Other mental health professional groups, including nurses, occupational therapists, clinical psychologists and social workers, have also indicated their support for recovery-oriented practice. We further endorse the recovery approach set out in *A Common Purpose.*

[3] *A Common Purpose: Recovery in Future Mental Health Services* was a joint position paper from the Care Services Improvement Partnership (CSIP), Royal College of Psychiatrists (RCPsych) and the Social Care Institute for Excellence (SCIE), published by the SCIE in 2007. It is available at http://www.scie.org.uk.

Executive summary

This position statement comes from the work of the Royal College of Psychiatrists' Social Inclusion Scoping Group, which covered the full range of people with mental health problems, addictions and intellectual disabilities represented by mental health specialties. The Scoping Group also highlighted the problems for specific social identity groups who have mental health problems.

The Royal College of Psychiatrists represents psychiatrists in England, Wales, Scotland and Northern Ireland. As a representative body, it is keen to engage with the challenges and opportunities for mental health and intellectual disability services and service users across all the countries and regions of the UK. One such challenge is the social exclusion of people with mental health problems in contemporary society, and opportunities to address this are presented by the advances made in treatment, services, approaches, attitudes and policy over the past 50 years.

Social exclusion

Social exclusion refers to the extent to which individuals are unable to participate in key areas of economic, social and cultural life. The emphasis here is on non-participation arising from constraint, rather than choice. The Scoping Group has taken a broad view of the socially inclusive perspective, including within it antidiscrimination laws, equality and human rights, social justice and citizenship, in addition to a clinical perspective. It is from this standpoint that the pernicious nature of exclusion and the importance of social inclusion for people with mental health problems and those with intellectual disabilities can be most clearly appreciated, and that the role which our social and political institutions have in making this happen can be best understood.

Social exclusion, mental health problems and intellectual disabilities

Social exclusion is an avoidable reality in the daily lives of many people with mental health problems or intellectual disabilities. These people are among the most marginalised and stigmatised groups in our society. There is clear evidence that they may be excluded both because they have inadequate material resources and because they are unable to participate in economic or socially valuable activities. They may be isolated and excluded from social relations and the wider community, and excluded from basic civil and political processes. Importantly, they may also be excluded from basic health and social services. These social disadvantages are associated with both physical and mental health inequalities. Disadvantage in early life increases the likelihood of disadvantage in later life; disadvantage may also be transmitted across generations.

Not only does social exclusion violate social justice and social solidarity, but exclusion and its indicators (e.g. joblessness, homelessness, poverty) are all associated with mental and physical ill health. These key concerns make enhancement of the status and participation of people with mental health problems and those with intellectual disabilities both a desirable outcome and the legitimate business of all health professionals.

Recovery and social inclusion

Recovery, in the sense used here, does not necessarily mean 'clinical recovery'; rather, it is concerned with 'social recovery', the idea of building a life beyond illness, of recovering one's life, without necessarily achieving clinical recovery. The ideas of recovery are integral to the notion of socially inclusive practice and can be applied to the whole range of people, of any age, with mental health problems and those with intellectual disabilities. Hope, a sense of personal control, and opportunity are key ideas relating to recovery. There is a creative synthesis between recovery and social inclusion: recovery both requires and allows social inclusion, and social inclusion helps to promote recovery. Both are key concepts for modern consultants and psychiatric practice.

Social inclusion and policy

Many aspects of social exclusion will require attention to structural changes in society and broader policy initiatives. Psychiatrists have a role to play in highlighting the associations between these policy and institutional factors and mental health problems.

Reducing the social exclusion of people with mental health problems and those with intellectual disabilities should be an explicit policy directive. The psychiatric profession can act as a constant advocate for the promotion of social inclusion in all policies that affect people with mental health problems or intellectual disabilities.

Socially inclusive practice and mental health services

A socially inclusive approach includes recovery-oriented practice, an emphasis on social outcomes and participation, and attention to the rights of people with mental ill health, as well as to citizenship, equality and justice, and stigma and discrimination. Mental health professionals and services must work in a socially inclusive and recovery-oriented manner. This can have benefits for service users, professionals and carers, in addition to wider economic and social benefits.

The challenges for the 21st century

A socially inclusive approach should be a key driver for the practice of individual mental health professionals and for the working and culture of mental health services in the 21st century. Psychiatrists must play a leading role in this.

The profession of medicine is becoming more collaborative, with a greater emphasis on patient self-care and choice, and greater recognition of the contribution of patients as experts in their own conditions. Psychiatry has to respond creatively and constructively to these challenges and each of the sub-specialties will need to adapt its practice in different ways.

As individual practitioners, psychiatrists are first and foremost doctors, and as physicians they have a wide expertise in psychological and social dynamics in their broader forms. They must build on their important existing skills and adapt these to socially inclusive practice. Psychiatrists need to approach the care of individuals and work with teams in an atmosphere of openness, collaboration and partnership.

This move to socially inclusive practice needs to be built into medical training at all levels, from the undergraduate curriculum to the establishment of competencies for the postgraduate curriculum for psychiatry. Continuing professional development for psychiatrists will be an important tool to promote the cultural change in attitudes and practice required to implement the social inclusion agenda across the profession.

The overall challenge is to develop, in mental health and intellectual disability services, a service culture that is socially inclusive, recovery-oriented and designed to deliver 'socially included' outcomes.

Some priorities for mental health and intellectual disability services are:

- the establishment of strong strategic relationships between health trusts, social services and social care and voluntary sector agencies, with mutually agreed strategic plans which recognise the contribution of each agency
- a recognition of the role of mental health and intellectual disability services in addressing ignorance, prejudice and discriminatory behaviour
- an increase in the number of people with lived experience of mental health problems or disabilities who are employed in mental health and intellectual disability services
- a greater emphasis on empowering service users to pursue their social goals
- a strengthening of the involvement of service users and carers in the planning of services and in research initiatives
- a recognition of the range of interventions that can improve both clinical and social outcomes for service users and ensuring that these are commissioned.

Mental health and social inclusion

The Fair Deal campaign

This position statement has been produced to support the Royal College of Psychiatrists' Fair Deal campaign (see http://www.fairdeal4mentalhealth.co.uk). The common thread running through the entire Fair Deal campaign is a drive for *equality*. Work is needed to address the inequalities in health, life chances and social inclusion encountered by people with mental health problems and intellectual disabilities. The Fair Deal campaign covers a range of issues and challenges. However, social inclusion is at its heart, and the campaign strongly subscribes to the following principles:

- People with mental ill health and people with intellectual disability should live in a fair and just society where their human rights are respected and each individual is able to realise his or her potential to the full.
- People with mental ill health and people with intellectual disability are entitled to an equitable distribution of the resources of the health and social care system. They should receive the same priority as patients with physical health problems wherever they present.
- There is *no health without mental health*. Mental health should be integrated into physical healthcare at all levels. This includes the mental health of people with physical illness in the general hospital setting.
- Discrimination and stigma need to be tackled throughout society. The National Health Service should lead in promoting equality and human rights. In particular, the quality of care must be the same irrespective of racial, religious or cultural background, gender, age, sexual orientation or diagnosis.
- The human rights of people with mental health problems and people with intellectual disability must be promoted and safeguarded. This applies particularly to those detained or deprived of liberty under mental health and mental capacity legislation.
- Healthcare services for people with mental ill health or intellectual disability should promote social inclusion and be delivered jointly by health and social care services and an array of third-sector organisations.
- Service users and carers must play a central role in the design and delivery of services.

The Fair Deal campaign also endorses a recovery-oriented approach and suggests that recovery-oriented practice and rehabilitation should be integral to mental healthcare and treatment (see pp. 11–12).

The context: society and mental health services in the 21st century

The context for this position paper lies in the changes in UK society that have occurred since the 1940s. While there were undoubted improvements in the quality of life and in the standards of living, health, education and housing during the 20th century, the income gap between the richest and poorest in the population widened. Inequalities increased and the numbers in relative poverty reached a historic high in the 1990s. Since then, there has been some reduction in relative poverty, but a high proportion of children still live in poor families and this is unlikely to be significantly reduced in the near future.

For many people, the experience of poverty, although unpleasant, is relatively brief. However, about 2–4% of the UK population live in persistent poverty and for others poverty may be a recurrent experience. People with multiple disadvantages are most at risk of poverty and social exclusion. Those who are jobless, older people, single parents and those who are long-term sick and disabled are overrepresented among those who are multiply disadvantaged, as are people with mental health problems and those with intellectual disabilities. People from Black and other minority ethnic groups are also more likely to experience social exclusion, especially if they are recent migrants or come from linguistically or culturally isolated groups.

There is little doubt that mental health services changed, and in many ways improved, during the latter part of the 20th century: the large institutions closed and most services are now provided in a community setting. Nevertheless, there is no place for complacency and, in the early part of the 21st century, it is timely to examine the state of mental health services, the standing of people with mental health problems and those with intellectual disabilities, and the ways in which psychiatrists and other mental health professionals can respond to these issues.

What is social exclusion?

Social exclusion refers to the extent to which individuals are unable to participate in key areas of economic, social and cultural life. The Scoping Group used the working definition of social exclusion produced by the Centre for Analysis of Social Exclusion (CASE): 'An individual is socially excluded if he or she does not partici-pate in key activities of the society in which he or she lives'.[4] The emphasis in this definition is on non-participation arising from constraint, rather than choice.

[4] Burchardt T, LeGrand J, Piachaud D. Degrees of exclusion: developing a dynamic, multidi-mensional measure. In *Understanding Social Exclusion* (eds J Hills, J LeGrand & D Piachaud). Oxford University Press, 2002.

Social exclusion is clearly just one way of conceptualising *disadvantage.* This has been traditionally seen in terms of 'poverty', 'hardship', 'destitution', all of which focus on material deprivation and the consequent personal distress. Social exclusion extends this traditional approach to go beyond non-participation due to lack of material resources. This allows expansion of the range of indicators and measures of disadvantage; it retains the objective of identifying individuals who lack the resources to participate but additionally identifies those whose non-participation arises in other ways (e.g. through prejudice, discrimination, chronic illness, cultural identification). Social exclusion and inclusion are concepts with moral and political connotations, particularly relating to stigma and discrimination, citizenship, justice and human rights.

People with mental health problems and those with intellectual disabilities may lack adequate material resources – they are often poor and have low incomes. They may find it difficult to participate in economically or socially valuable activities such as employment and education. They may be isolated and excluded from social relations and neighbourhoods and the wider community.

People with mental health problems or intellectual disabilities may also be excluded from basic civic and political processes. People with mental health problems should be able to be involved in local or national decision-making (i.e. to have a voice, choice and control) and be able to engage in the wider aspects of civil society that may, in turn, influence their lives. Historically, engagement in civic participation has been low among people with severe mental health problems. The right to vote is restricted for many detained patients and the participation of service users in elections is often marginal. Many people with intellectual disabilities or a diagnosis of mental disorder are also ineligible to serve on juries. In the extreme case, Members of Parliament will automatically lose their seat if they are detained under the Mental Health Act for 6 months, but would not do so if they were unable to perform their duties owing to a physical illness for this period of time.

Viewed in this broader way, social exclusion is not just about exclusion from social roles – it is also about reduced access to basic services. For example, the range of health inequalities alluded to above reflects lack of inclusion in a range of health services. These may be self-imposed (lifestyle 'choices') or arise as a result of 'system' problems (e.g. unresponsive services). People with significant mental health problems are certainly at much greater risk of serious physical health problems. They are more likely to get heart disease, diabetes and some cancers, especially when young and, once diagnosed, are more likely to die within 5 years. They are also less likely to get some of the expected evidence-based checks and treatments; they often do not have their physical health problems fully explored or treated. A recent inquiry into physical healthcare for people with intellectual disabilities[5] found evidence of good practice but also appalling examples of discrimination, abuse and neglect across the range of health services. This may reflect low expectations among health service personnel about the extent to which people with mental health problems or

[5] Michael J. *Healthcare for All. Report of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities*. IAHPLD, 2008 (http://www.iahpld.org.uk/Healthcare_final. pdf).

intellectual disability 'want' to participate in health services designed to improve their physical health. It may also reflect inadequate attention being paid to the need for 'reasonable adjustments' (as described in the Disability Discrimination Act) to ensure that public bodies accommodate to the special needs of particular groups. Screening programmes for the general population may not meet the needs of those with mental health problems or intellectual disability.

There are thus multiple indicators suggesting that social exclusion is detrimental to people with mental health problems and to those with intellectual disabilities. What is the importance and relevance of this for psychiatry?

Social exclusion and psychiatry

There are several reasons why psychiatry should be concerned about social exclusion, but the central concern is the fact that exclusion and its indicators (e.g. joblessness, homelessness, poverty) are all associated with mental and physical ill health. The enhancement of the status and participation of people with mental ill health and people with intellectual disabilities is in itself a desirable outcome and the business of all health professionals. The associated aspects of discrimination, social justice, human rights and citizenship therefore all become the legitimate concern of psychiatry.

Social exclusion violates the value of social justice and it despoils the value of social solidarity. Here, social justice is equated with the substantive opportunity for people to choose to lead the kind of life they value, which may be limited for people with mental ill health or intellectual disabilities. Human lives tend to go better in a society whose members share some kind of common social existence and social justice is more likely to be realised through processes that lead to higher levels of social solidarity.

These matters point to the need to contest the ignorance, prejudice and discrimination that people with mental health problems or intellectual disabilities face in exercising their basic human rights. Underlying these are several factors that reflect why psychiatry should be concerned with the social inclusion of people with mental ill health.

There are strong associations between poverty, disadvantage, deprivation, exclusion and mental ill health
Mental ill health is both a *cause* and *consequence* of exclusion and there are complex and multidimensional relationships between disadvantage and mental illness. There are, thus, fundamental reasons why psychiatry cannot ignore social exclusion.

Social disadvantage, poverty and mental health problems (and intellectual disability) tend to go together
In the UK, there is a higher incidence of severe intellectual disability in lower social classes. Mental health problems, defined broadly, are more common among the poor than among the rich by about a quarter (the prevalence of people with *any* type of mental health problems among the poorest 14% of the

population is almost 30%). However, people with a diagnosis of psychosis are *nine* times more common among the poor than the rich. These income-related differences are more pronounced among children than they are among adults, with the prevalence of *any* mental disorder being three times as high among children living in the poorest 15% of households compared with those in the top income range.

The low incomes of people with mental health problems means that many are not able to afford basic necessities, such as adequate heating. Domestic appliances, holidays and common social activities may be seen by them as luxuries. They are unlikely to have any significant savings or capital and often do not have a bank account. They may also be in debt and unable to afford insurance or other financial services. The low income of people with severe mental health problems may restrict their travel opportunities, as most will not be able to afford a car, discretionary transport or holidays. This reinforces isolation and may also affect access to services.

A possible link between poverty, exclusion and mental ill health is the lack of a 'sense of control'. Lacking the basic necessities and the possibility of addressing these deficits reduces individuals' sense of control over their lives. The experience of a lack of control over one's material and social circumstances may then act as a mediating factor between poverty and poor mental health. It is important to tackle poverty if individuals are to thrive – and this includes individuals with mental health problems and with intellectual disabilities. Poverty is harmful to individuals and to society. It is a waste of human resources and a measure of the failure of the welfare state.

Poverty and exclusion are not fixed states

Their impact will vary over time. They may be transient, recurrent or long-term experiences. People will move in and out of the conditions (poverty, unemployment, ill health) that lead to exclusion, but people with mental health problems may be prevented from doing so, for example by inadequate and untimely treatment of their mental health problems. This may be compounded by mental health services which pay inadequate attention to the financial, employment and other social circumstances that exacerbate exclusion.

Exclusion is brought about by someone or something

Exclusion involves reciprocal interactions between individuals and groups and wider social structures. Exclusion cannot exist without someone or something bringing it about and this may be the behaviour of individuals or the workings of 'systems' (e.g. institutional failures). The causes of exclusion are multi-level (individual, household, community, institutions) and the remedies cannot therefore be found solely at the level of the individual. Our sights must be set wide, to cover such areas as the functioning of services, the workplace and the welfare and legal systems.

Exclusion affects everyone

The relative nature of exclusion means that the same general contemporary social forces act upon all people in the population, including those with mental

health problems. Reducing the differences between those with mental health problems and others, be it because of income, employment, or choice and control, will have beneficial effects for everyone. Possible actions may include improving access to benefits, employment, training, education and social participation.

People who are excluded often suffer from multiple disadvantages
The causes of these multiple disadvantages can be located at several different and interacting levels. This implies that the responses must be directed at multiple targets and aimed both at individuals and at wider structures, by using a range of agencies (e.g. health, social care, education, housing).

Exclusion affects families and can pass from generation to generation
Mental health problems have a profound impact on families. Up to 420 000 people in the UK care for someone with a mental health problem, including 6000–17 000 young carers. Carers are twice as likely to have mental health problems themselves if they provide substantial care. One-third to two-thirds of children whose parents have mental health problems will experience difficulties themselves. These disadvantages tend to pass from generation to generation and can affect the life chances of multiple family members. This implies the need for early intervention, prevention and promotion to break these 'cycles of disadvantage'.

Some areas of the country are more deprived than others
The causes and consequences of social exclusion cluster in particular geographical areas, with some of these areas having the highest levels of disadvantages across a number of indicators of deprivation (e.g. unemployment, poor housing, high crime rates, poor access to healthcare). A higher proportion of people using mental health services tend to live in deprived neighbourhoods and most people with severe mental health problems live in social housing, which may be of poor quality, in poor repair, damp, noisy or lacking security. These housing problems may coexist alongside poverty, appear independently, or in combination.

Although much attention focuses on violence by people with mental illness, it is actually more likely that they will be victims than perpetrators of violence or other forms of crime. Some of this may be associated with the more impoverished neighbourhoods in which people with severe mental health problems tend to live. Personal safety may be a particular concern for older people with mental health problems. People with intellectual disabilities are particularly vulnerable to abuse and exploitation and to being targeted in their local communities.

All this points to the need for mental health services to be responsive to the nature of the local area and to adapt and focus resources accordingly.

Exclusion is a profoundly negative experience for the individual
Much objective evidence exists on the social exclusion of people with mental health problems or intellectual disabilities, but there is also a subjective dimension to both social exclusion and inclusion. Inclusion is experienced by individuals as a state of belonging and involvement in local communities, which is determined

by the actions of others. This emphasises the lived experiences of people with mental illness and how society's responses contribute to excluding them from social activities and social spaces. One of the most important subjective dimensions is that concerned with the low expectations of mental health professionals as to what people with mental health problems can achieve. This can create a situation of 'self-stigmatisation', where people come to believe the low expectations that others have of them.

People with intellectual disabilities may be excluded from local services because they are perceived to have behaviours that are difficult to manage, which may lead to an increasing burden on carers, a negative effect on self-esteem and placement in services away from their local areas.

People want to participate

Perhaps the most compelling reason for adopting socially inclusive principles is that this is what most service users want. People generally do better in services that embrace social inclusion, with mental health professionals who are able to minimise the impact that illness has on social functioning and with opportunities for people to be included in key social roles, such as employment and personal and social relationships.

Inclusion is pertinent to the experience of service users, for whom major priorities are not only the reduction of poverty but also a desire for a role, more friends and relationships, acceptance by neighbours, employers and families, and more opportunities to be part of mainstream groups and communities. In concerning ourselves with social inclusion we are therefore responding to the direct wishes of service users.

The importance of 'recovery'

The Royal College of Psychiatrists has already given explicit support to the recovery approach in an important position paper, *A Common Purpose*. Recovery ideas are integral to socially inclusive practice. Recovery-oriented practice and services should form some of the key approaches to socially inclusive practice.

Social inclusion is important for recovery: people with mental health problems and those with intellectual disabilities should be a part of our communities, not apart from them; they should be valued members of those communities, have access to the opportunities that exist in those communities and have the opportunity to contribute to those communities.

'Recovery' is not a new term and, in the sense used here, does not necessarily mean 'clinical recovery' (usually defined in terms of symptoms and cure). Rather, it is concerned with 'social recovery', the idea of building a life beyond illness, of recovering one's life, without necessarily achieving clinical recovery. In this way, 'recovery' in the field of psychological disability has a common theme with other chronic illnesses, such as diabetes, asthma and arthritis. Central to recovery is the development of a sense of personal control (*agency*), and sustaining motivation and supporting the expectations of an individually

fulfilled life (*hope*). It thus involves self-management and self-determination, rather than professionally dominated strategies.

Recovery concepts have been largely formulated by, and for, service users to describe their own experiences in trying to build a life for themselves in the face of enduring mental health problems. However, for recovery to have the impact it deserves, professionals need to understand what it means and, together with service users and others, actively support its implementation across services. This will require changing the way in which mental health professionals work, as well as the structure, orientation and culture of services, to become more *recovery-oriented* and directed towards efforts to reduce exclusion.

Many of the ideas of recovery are especially pertinent at the turn of the 21st century, when most mental health services are now provided in a community setting and there is an ever-increasing and significant service user movement, which has developed its own articulate voice. Along with a socially inclusive orientation, these recovery ideas represent key components for the transformation of mental health services and practice in the future.

The concepts of recovery have already been taken up by policy initiatives in several countries, including New Zealand, Australia, the USA, Ireland and Scotland. In England, these ideas are supported by Department of Health policies that promote self-management and choice.

In mental health services, recovery ideas have received most attention in relation to working-age adults and rehabilitation practice (there are strong connections to rehabilitation services, and recovery offers a new conceptual framework for rehabilitation practice). They can, however, be applied to anyone who experiences a significant mental health problem, at any age. They can also be applied in specialist areas such as forensic mental health services, brain disorders and drug and alcohol services.

Recovery ideas provide a means of changing our own practice, as they require a different relationship between service user and professional. But they also necessitate a modification of the way in which we organise mental health services, emphasising more the objectives of housing, employment, education and participation in mainstream community and leisure activities and the role of services themselves in identifying and driving the development of capacity in these key domains.

Complementing this, there is a critical need for inclusively oriented services and practice to be a core part of mental health services. Opportunity and optimism are key ingredients of both social inclusion and recovery. There is a creative synthesis between these two approaches: recovery both requires and allows social inclusion and social inclusion helps to promote recovery. Both are key concepts for modern consultant roles and for modern psychiatric practice.

The benefits of working in a socially inclusive way

Although many aspects of inclusion will require attention to be paid to structural changes in society and to broader policy initiatives such as taxation and welfare

reform, psychiatrists and other mental health professionals in their everyday work have a significant role to play. If the social inclusion of people with mental illness is to be given greater impetus in mental health policy and practice, then leadership is required from psychiatry and the other major mental health professions, in partnership with the service user movement and with carers' organisations. This will necessitate realignment between professionals and service user groups (and carer groups) and the creation of new forms of collaboration.

The complementary concepts of social inclusion and recovery provide common ground between psychiatrists, other mental health professionals and service users. Working in a socially inclusive manner can therefore build on what has been developed over the past 10–15 years, but is also an opportunity to make new, more radical, contributions to the future. It is important that psychiatrists actively contribute to this opportunity and are at the forefront of these changes to mental health services in the 21st century.

Benefits to service users, professionals and carers

Many benefits for professionals and service users may accrue from the development of more collaborative relationships. In the first place, delivery of care that uses socially inclusive and recovery approaches, in line with service users' preferences and choices, is likely to lead to better outcomes for service users. Working with service users' preferences and choices as far as possible is more likely to enable them to live the lives they want to lead.

Similarly, informal carers can be seriously affected by their own perceptions and experiences of ignorance, prejudice and discrimination in relation to their relative's mental health problems, and relationships within the family and informal support network can be strained beyond repair during periods of repeated relapse and readmission. Interventions from mental health services to assist carers and families (such as family psychoeducation) have been shown to be extremely effective in sustaining these key social support networks. These interventions are difficult to implement and maintain, but their importance cannot be overstated in minimising factors likely to exacerbate social exclusion.

Economic benefits

Social exclusion is not only unjust, it is also extremely costly – both to the health and well-being of individuals and their families and to society as a whole. Reducing exclusion by improving employment opportunities for people with mental health problems could yield substantial economic benefits. In part, these benefits would accrue to the individuals themselves in the form of higher incomes, but there would also be gains for the wider community. For example, government revenues (and hence the scope for public spending) would increase, because of income tax and national insurance contributions payable on the extra earnings, and there would also be savings in social security spending as people move from benefits into work. In addition, there would be savings in the costs of care for those whose mental (and physical) health improves as a result of gaining employment.

A similar argument may be applied to alcohol and drug dependence. The cost to the country of alcohol misuse is about £20 billion a year, with substantial

amounts spent on imprisonment. If these problems could be tackled, there would be wider social benefits in terms of reduced crime, fewer accidents, greater productivity and less neglect of children.

There are also potential economic benefits from breaking the cycle of deprivation that affects the long-term outcome of individuals and families. Giving attention to impaired relationships in early life helps to address the potentially destructive long-term effects of stressful attachment. For example, conduct disorder carries a huge cost for society, yet it is primarily a treatable condition. However, such interventions are difficult to establish and it would require a new political imperative before National Health Service funding could be directed towards realising the social benefits arising at a time and place so far removed from the psychiatric clinic.

Social benefits
Greater inclusion, through improvement of individual social networks and support, offers some protection from the onset and continuation of mental health problems. Lower levels of objective and subjective social capital are associated with higher levels of symptoms in both adults and children, which suggests that access to a well-developed social network may have benefits for individuals over and above improving their subjective sense of 'belonging'. This may be particularly true for people with psychotic symptoms, where the poverty of their social networks may give rise to specific problems of support in times of crisis. These networks may also facilitate access to economic, cultural and information resources, which then benefit the individual. However, it is not sufficient to think in terms of simply enhancing factors related to 'social inclusion' (employment rates, access to decent housing, etc.) without thinking of the wider social context in which such interventions will operate (friends, families, the wider public). These wider social benefits transcend the achievement of therapeutic goals.

At the collective level, social capital is a characteristic of *communities*, a 'community stock' which strengthens the fabric of society and promotes values such as citizenship, reciprocity and diversity. These benefits may spread through the community, improving its collective health and thereby the health of its individual members. This view has plausibility and there is some supporting evidence in relation to reduced levels of suicide and improved outcomes for people with schizophrenia.

Is there evidence for the effectiveness of interventions aimed at reducing both mental ill health and exclusion?

Many of the changes that will benefit people with mental ill health in their struggle to have a life they value and choose, and to address the discrimination and prejudice that they meet each day, will be achieved through changes in society and by efforts at a national level. Nevertheless, there are a number of existing interventions, with strong evidence of effectiveness, that address

both social exclusion *and* mental ill health. Examples include family interventions for conduct disorder and related behavioural disorders in children, early intervention in first-episode psychosis, and supported employment for people with schizophrenia. They are best seen in the context of 'secondary prevention'. Further evidence is available for methods of supporting people with intellectual disabilities who present behavioural challenges and for assertive outreach approaches for people with intellectual disabilities.

Family interventions for conduct disorder
Longitudinal studies indicate a high degree of persistence (continuity) between adverse mental states in childhood (e.g. conduct disorder) and those in adult life. The social and economic costs of conduct disorder are high, and can include criminal behaviour, substance misuse, poor educational and labour market performance and disrupted personal relationships. Parenting skills training improves the mental health and behaviour of children, and many of the beneficial effects persist into adulthood, subject to some attenuation as children pass through adolescence into adult life. The long-term benefits include both higher earnings for programme participants and savings for the wider community, mainly in the form of reduced welfare and crime-related costs and higher taxation associated with higher earnings. Children brought up in the worst conditions in terms of economic deprivation and related environmental stressors benefit most.

Early intervention in first-episode psychosis
The first episode of schizophrenia occurs predominantly when people are young (aged 16–30 years) and can lead to long-term, even lifetime, problems, putting those affected at particularly high risk of social exclusion. Research studies from a number of countries now provide evidence that early intervention after first onset, based on quicker detection and treatment by specialist teams, is not only feasible but also cost-effective and leads to improved clinical outcomes (e.g. lower relapse rates, lower use of legal detention, fewer hospital admissions, better service engagement, lower suicide rates) and improved social outcomes (employment, training and education). In many studies, these benefits are demonstrated only over a relatively short time (1 or 2 years) but there is now increasing evidence to suggest that at least some of the gains persist into the longer term.

Supported employment for people with schizophrenia
People with long-term mental health problems, especially those with a diagnosis of schizophrenia, have the lowest employment rate of any of the main groups of people with a disability and represent the highest number of people claiming sickness and disability benefits. There is now a substantial body of evidence to demonstrate that much better, and cost-effective, outcomes can be achieved by supportive employment, particularly 'individual placement and support' (IPS) models, which emphasise rapid placement in work and ongoing support after placement ('place and train'), in contrast to the traditional 'train and place' models, which focus on a prolonged period of assessment and preparatory training. The effectiveness of IPS has consistently been demonstrated in randomised

controlled trials in the USA, Canada, Europe, Hong Kong and Australia, and has been successfully deployed in routine clinical practice in a number of National Health Service trusts. This evidence is strong enough to recommend implementation of IPS as routine practice for specialist mental health services which aim to improve the employment rate (and thereby social inclusion) of people with long-term mental health problems.

Services and practice – the challenges for the 21st century

For mental health services, a socially inclusive approach includes recovery-oriented practice, an emphasis on social outcomes and participation, and attention to the rights of people with mental ill health or intellectual disability, as well as to citizenship, equality and justice, and stigma and discrimination. Many of these matters will require structural changes in society and broader policy initiatives. Psychiatrists have a role to play in highlighting the associations between these policy and institutional factors and mental health problems.

Psychiatrists will need to examine the nature of their relationship with service users and the nature of their training. For mental health services, the changes that must be made relate to practice, service orientation and culture. Psychiatrists need to be part of this and play a leading role.

Individual practice and team working

The profession of medicine is changing. It is becoming more collaborative, with a greater emphasis on patient self-care and choice, and greater recognition of the contribution of patients as experts on their own conditions. Psychiatry has to face these challenges and each of the subspecialties will need to adapt its practice in different ways. Achieving 'socially inclusive' mental health services that support individuals on their own unique journey of recovery represents considerable challenges for psychiatrists, both as individual practitioners and as members of specialised teams. The implications of these changes are multiple. It is important that psychiatrists build on their important skills and adapt these to support socially inclusive practice and begin to create new forms of relationships with service users and carers which are based on partnership.

Individual practice

As individual practitioners, psychiatrists are first and foremost doctors. Psychiatry is a medical specialty and psychiatrists are physicians. But they also have a wider expertise in psychological and social dynamics in their broader forms. They are also sensitive human beings who may sometimes be called upon to use their life experiences to inform their work. They therefore need to have a wide range of skills, significantly beyond the delivery of a narrow, 'biomedical' model.

Psychiatrists possess what might be called 'basic' therapeutic skills, including empathy, acceptance and mutual affirmation. For a recovery-oriented approach, these may be formulated in terms of the ability to work with the service user

and significant others to formulate a shared understanding of the problem and a positive, forward-looking plan which is implemented with clear, structured feedback regarding progress. They need to take up the lead from the National Social Inclusion Programme (NSIP) and adopt its helpful list of 'ten shared capabilities'[6] necessary for inclusive practice in their work and training. These capabilities underpin the New Ways of Working initiative and include:

- working in partnership
- respecting diversity
- challenging inequality
- identifying individual needs and strengths
- promoting safety
- responsible risk-taking.

Psychiatrists also need to adopt practical ways of conducting interactions centred on the service user and utilise useful pointers such as the Sainsbury Centre's '10 Top Tips for Recovery-Oriented Practice',[7] which overlap with these key capabilities and emphasise the importance of prioritising the service user's goals wherever possible and demonstrating a belief that they can be achieved ('maintaining hope and optimism'). Additionally, recovery-oriented approaches use a combination of professional help, self-help and non-mental health resources (such as friends, families, employers, education bodies) to help service users achieve their goals.

Psychiatrists who work in a more socially inclusive way may therefore need to redefine their relationship with service users. This does not mean that they need to abandon their traditional medical skills of assessment, diagnosis and treatment. They need to continue to deliver these within a different context, one which recognises the skills of other disciplines and the experience and knowledge of users themselves. This shift towards a more socially oriented model may present a daunting project for the average, working psychiatrist and, of course, not every practitioner will excel in every area. That is where teams come in.

Team working

Specialised teams – for example, working in assertive outreach, crisis resolution, early intervention, community, intellectual disability or primary care – now form the bedrock of modern adult mental health services. One of the key rationales for teams is that they can provide access to the range of specialist skills and expertise necessary to provide a holistic assessment of needs and a comprehensive plan of treatment and management for people with multiple and complex problems.

From a socially inclusive perspective, the role of the psychiatrist is to help ensure that teams contain the complete range of necessary skills, covering all the areas that are likely to have an effect on illness and outcomes. This includes the areas of finance, housing, employment and social integration. The psychiatrist is also in a key position to ensure that service users and their carers

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[6] Department of Health. *Capabilities for Inclusive Practice*. Department of Health, 2007.

[7] Shepherd G, Boardman J, Slade M. *Making Recovery a Reality*. Sainsbury Centre for Mental Health, 2008.

are included as part of this team. Guidance from the General Medical Council (GMC)[8] regards the establishment of these collaborative partnerships as central to the role of modern doctors.

There is then the vexed question of *leadership*. Psychiatrists must lead on the medical work of the team and for many aspects of medico-legal practice. Other professions will 'lead' – in the sense of taking accountability – for practice in their specific areas of expertise. In terms of the overall management of the team and the efficient integration of this network of individual responsibilities, psychiatrists may also take this role.

However, today many teams have 'managers' who are not medical and who are specifically appointed to take on coordinating responsibilities. They need to be experienced and to have good formulation and problem-solving skills, as well as the ability to commit all members of the team to shared plans of action. Some psychiatrists have these skills and some do not.

There is also often more than one 'leader' in the team: the 'task leader', who delivers the tasks outlined above; and the 'socio-emotional leader', who helps bind the team together, maintaining morale, encouraging involvement and participation. These two leaders may or may not be the same person. Psychiatrists may function in either or both of these roles.

Finally, we need to consider the role of socially inclusive psychiatrists at a strategic level, influencing how services develop, their overall direction and priorities. Psychiatrists should ensure that they are in a position to listen to the views of service users and carers and that these views are fed into local service development priorities. This means supporting the involvement of service users and carers in local planning groups.

Mental health services

The overall challenge is to develop, in mental health and intellectual disability services, a culture that is socially inclusive, recovery-oriented and designed to deliver 'socially included' outcomes.

Socially inclusive and recovery-oriented services must have strong strategic relationships with the necessary range of social care agencies, for example housing, employment or community networks. The requirement is not just for good working relationships between individual practitioners, but also for mutually agreed strategic plans which recognise the contribution of each agency. Such 'partnership agreements' need clear, realistic goals, transparent commitment of resources and agreed methods for monitoring progress, so that both sides can be satisfied that the partnership is working. They may be facilitated by the appointment of 'bridge builders' in each team to take on liaison responsibility with specific agencies.

In the future, partnerships of this kind may be dedicated to joint delivery arrangements, where commissioners specify what they expect from each agency in the delivery of joint outcomes from their working together (e.g. mental health teams and employment providers working together to resettle

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[8] General Medical Council. *Good Medical Practice*. GMC, 2006.

and maintain people with mental health problems in the workplace). Psychiatrists may play a key role in overseeing these arrangements and ensuring that the commissioning requirements describing the contribution of mental health teams are both professionally sound and practically feasible.

In some inter-agency partnerships, psychiatrists may also have a key role in addressing stigma issues. Employment providers, housing staff and benefit officers, for example, may all begin with rather negative attitudes towards dealing with people with mental health problems. These stigmatising attitudes are usually based on a mixture of ignorance, prejudice and behavioural discrimination. Psychiatrists may thus play a key role in de-stigmatising people with mental health problems through, for example:

- contributing to staff education (addressing ignorance)
- facilitating face-to-face meetings between service users and staff in the agencies who hold these attitudes (addressing prejudice)
- identifying illegal discriminatory behaviour.

Doctors continue to be held in high esteem by the general public and putting their weight behind these kinds of initiative at a local level can be extremely powerful.

Perhaps the most radical way of transforming mental health services to be more centred on the objectives of service users (which are usually 'social') is to increase in the workforce the number of people with lived experience of mental health problems. There are examples from the USA and England of mental health services which have transformed themselves by changing the workforce in this way. This can be done by both employing 'peer specialists' to work in teams and by openly employing people with lived experience in the general trust workforce.

Pursuing social goals through the development of completely new relationships between psychiatrists (and other professionals) and service users may therefore herald some fundamental changes to mental health services. These are necessary and welcome and psychiatrists must be involved in shaping and influencing these changes at a national and a local level. Their roles in the new systems will be different, but their contribution is still vital.

Training

It is important that the principles of social inclusion and recovery are embedded in the training of future psychiatrists, whether they be medical students or psychiatric trainees, and in the continuing professional development of consultant psychiatrists and non-consultant grades.

In addition to providing the key aspects of knowledge, skills and attitudes relating to psychiatry, the undergraduate curriculum needs to make future doctors aware of the ignorance, prejudice and discrimination faced by people with mental health problems or intellectual disabilities, as well as the importance of developing partnerships; it should help students to review their preconceptions, assumptions and prejudices about people with mental health problems or intellectual disabilities. Students need to understand the nature of the association between social conditions and ill health, including mental health problems and intellectual disability.

The competencies relevant to socially inclusive practice should be included in the postgraduate curriculum for psychiatry, including those relating to patient self-management. Competencies relevant to each subspecialty should be developed. All psychiatrists must understand the influence of social factors on the incidence and prevalence and outcomes of mental health conditions and intellectual disabilities. They should feel that they have a contribution to make to these social objectives as part of their role as psychiatrists, and even if they do not have great expertise in these fields themselves, they do need to know someone who does. In order to understand the importance of these factors, as well as studying them, psychiatrists should be required to conduct at least one project in their training which involves working with a non-health, social care agency, service users and carers.

Psychiatrists need to approach the care of individuals and working with teams in an atmosphere of openness, collaboration and 'partnership'. This is how all doctors will be expected to behave in the future. Continuing professional development, a central requirement for all psychiatrists, is an important tool to promote the cultural change in attitudes and practice required to implement the social inclusion agenda across the profession.

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