# Social inclusion, social quality and mental illness

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It has been argued that people with a significant mental illness are among the most excluded in society. Sayce (2001), for instance, has proposed that psychiatrists should directly embrace social inclusion and recovery as treatment goals. They should indirectly contribute by engaging in the wider social policy debate, including for example issues relating to the disability rights agenda. Controversially, she has suggested that the UK Disability Rights Commission now has a more significant role to play than the National Service Framework for Mental Health in promoting the social inclusion of people with mental health problems.

## MEANINGS OF SOCIAL EXCLUSION

It is possible to derive two quite different meanings for social exclusion, with different evidential bases, and with different implications for social and clinical action. The first concept of social exclusion, *Demos*, has implications for citizens' rights; the other, *Ethnos*, has more-significant implications for the practising clinician (Berman & Phillips, 2000). A nation state can achieve the state of *Demos* when it is inclusive in its definition and realisation of citizenship, and when citizen status leads to equality of social, political and legal rights (Marshall, 1973). Congruence between *Demos* and any nation state will be highest where social inclusion and social cohesion are maximised, but not when a large proportion of the people of the country are denied full citizenship. In other words, *Demos* refers to the range of access rights which are offered by citizenship of a given nation state. Nevertheless, this is a complex concept and within multi-ethnic societies there will often be differentiated social status and access to rights for different ethnic and cultural groups (Shaw, 1988).

By contrast, *Ethnos* refers to a shared cultural community rather than a national community, and to the shared values, identification and sense of cohesion that are engendered by membership of particular social groups and communities. McMillan & Chavis (1986) have identified four components which make up an *Ethnos* community: membership, influence, integration and fulfilment of needs, and a shared emotional connection. As Berman & Phillips point out:

'These elements are socio-psychological in nature. They do not exist on the bases of rights or formal identification. Rather, community exists as an interplay between the individual and the group. It requires reciprocity between individuals within the community. Thus, community in this framework is a matter of choice and not a right or an obligation. The implications of such a relationship are that to be a member of a community demands an investment and some action within the community framework. Inclusion/exclusion is not a matter of the manifestation of social rights but the manifestation of identification and/or social participation'.

Indicators of social exclusion originating from *Demos* will measure the unavailability of rights and services to those who, by definition of citizenship, should have access to them, including discrimination where this prevents access to the help that is needed. Such indicators would include information in the following domains: social security, employment, housing, health, education and community services; and also the democratic process or measures of social quality, such as legislation regarding access to services for people with disabilities, regardless of their cultural background. The direct contributions that psychiatrists, or general practitioners for that matter, can make include their role in assisting mental health service users to apply for, gain or retain housing. Although some of these powers, for example through the local Medical Officer of Health's department in the local authority, have been eroded over the past 25 years, they

are now re-emerging as legitimate concerns. More indirectly, the Royal College of Psychiatrists' campaigns for greater awareness of depression and against stigma are both examples of attempts to address rights and service issues at the national level, as are the College's reports on community care (Royal College of Psychiatrists, 2000) and on the employment of people with severe mental health problems (Royal College of Psychiatrists, 2003).

However, indicators of social exclusion originating at the level of *Ethnos* measure not accessibility to citizenship rights, but rather the degree of individual identification and participation in the wider social milieu. Perceptions of access, for example between different ethnic groups, may be important as indicators of *Ethnos*. As Berman & Phillips put it:

'These domains are psycho-social in nature in the sense that they relate to the consciousness and significance of the interaction and relationship between a person and his/her identified community. Social exclusion in the community–individual relationship is a result of the weakness of social bonds which is a subjective phenomenon'.

## EXCLUSION FROM PARTICIPATION IN THE WORKFORCE

Insofar as social exclusion arises from *Ethnos* sources, clinicians may be able to exert even greater direct influence. Patients' aspirations for participation are very similar to those of the wider community (Evans & Huxley, 2000; Thornicroft *et al*, 2002) and there are a number of life domains where significant individual improvements can be achieved: many people with more-disabling mental disorder have a low starting point. One key area of social exclusion is unemployment (Warr, 1987). The employment level of psychiatric patient populations rarely reaches more than 10%, and when working they work fewer hours and earn only two-thirds of the national average hourly rate (Meltzer *et al*, 1995; Evans & Huxley, 2000; Office for National Statistics, 2002).

The cost of excluding people with mental health problems from the workforce is immense. People with mental disorders constitute 39% of all claimants of Severe Disablement Allowance and 34% of Incapacity Benefit claimants, according to recent figures (Department for Work and Pensions, 2002). If psychiatrists could help

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to prevent people who develop a mental illness while in employment from losing their jobs and progressing on to long-term benefit, they would significantly reduce the economic burden of social exclusion. One way of doing this would be to use the concept of 'reasonable adjustments'. Thus, where changes are made by the employer, such as offering more flexible hours or temporarily limiting the scope of a person's responsibilities at work, the person can continue to work rather than take sick leave. This would mean that psychiatrists would adopt a highly active role in supporting the continuation of employment for those who are temporarily unable to work.

## SOCIAL EXCLUSION AND INCOME

A major factor enabling people to participate in community leisure activities is their income level. Studies have found that about half the patients in contact with a community mental health service in England were not receiving the full amount of welfare benefits to which they were entitled (e.g. McCrone & Thornicroft, 1997). Both the inherent nature of mental health problems and discriminatory responses to them have deleterious effects on interpersonal relationships, leading to reduced social contacts. Patients are four times more likely than the average not to have one close friend, and more than one-third of patients say that they have no one to turn to for help (Meltzer et al, 1995; Evans & Huxley, 2000). The receipt of less than full welfare benefit entitlement may contribute to further erosion of the social networks of people with severe mental health problems, because they are less often able to engage in sharing the costs of social and leisure activities (Cattell, 2001). Psychiatrists may also have a role here in establishing or supporting schemes which offer expert welfare benefits advice to service users, and by actively referring to such facilities.

## SOCIAL QUALITY

By providing the help necessary to enable people to remain socially included, or to rejoin their leisure, friendship and work communities, psychiatrists can make a significant contribution to the improvement of 'social quality'. This has been defined as 'the extent to which citizens are able to participate in the social and economic life of their communities under conditions which enhance their well-being and individual potential' (Beck et al, 1997). Social quality refers to the concepts of social inclusion and also socio-economic security, social cohesion and empowerment (Social Exclusion Unit, 2000; Putnam, 2001). It is in these areas that psychiatrists, together with others who provide mental health and associated services, can help to make a real difference to the course, consequences and outcomes of mental disorders, both for the patient and for the communities of which they are a part (Watt, 2001). Interventions designed to have an impact upon social inclusion through *Demos* channels would include enhancing structures that promise and deliver greater access to services. Actions by psychiatrists to achieve service improvement through *Ethnos*-related measures would, for example, relate to greater emphasis within the psychiatric training curriculum on understanding the interrelationships between ethnic minority culture and the experience of mental illness. There is in turn an interplay between these two domains: *Ethnos*-related measures are unlikely to be effective without concurrent *Demos*-related changes. The undertaking of such activities by psychiatrists may eventually lead to greater social inclusion and a reduction of the stigma of mental illness.

## DECLARATION OF INTEREST

None.

## REFERENCES

**Beck, W., van der Maesen, L. & Walker, A. (eds) (1997)** *The Social Quality of Europe*, p. 3. The Hague: Kluwer Law International.

**Berman, Y. & Phillips, D. (2000)** Indicators of social quality and social exclusion at national and community level. *Social Indicators Research*, **50**, 329–350.

**Cattell, V. (2001)** Poor people, poor places, and poor health: the mediating role of social networks and social capital. *Social Science and Medicine*, **52**, 1501–1516.

**Department for Work and Pensions (2002)** *Incapacity Benefit and Severe Disablement Allowance*. London: DWP.

**Evans, S. & Huxley, P. I. (2000)** Quality of life measurement in mental health: some recent findings. In *Proceedings of the Third Conference of the International Society for Quality of Life Studies* (eds F. Casas & C. Saurina), pp. 271–282. Girona, Spain: Institut de Recerca sobre Qualitat de Vida, University of Girona.

**Marshall, T. (1973)** *Class, Citizenship and Social Development*. Westport, CT: Greenwood.

**McCrone, P. & Thornicroft, G. (1997)** Credit where credit's due. *Community Care*, September, 18–24.

**McMillan, D. & Chavis, D. (1986)** Sense of community: a definition and theory. *Journal of Community Psychology*, **14**, 6–23.

**Meltzer, H., Gill, B., Petticrew, M., et al (1995)** *Economic Activity and Social Functioning of Adults with Psychiatric Disorders*. Office of Population Censuses and Surveys, Surveys of Psychiatric Morbidity in Great Britain, Report 2. London: HMSO.

**Office for National Statistics (2002)** *Labour Force Survey 2002*. London: Stationery Office.

**Putnam, R. (2001)** *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon & Schuster.

**Royal College of Psychiatrists (2000)** *Community Care* (Council Report CR86). London: Royal College of Psychiatrists.

**—— (2003)** *Employment Opportunities for People with Psychiatric Disabilities* (College Report CR111). London: Royal College of Psychiatrists (in press).

**Sayce, L. (2001)** Social inclusion and mental health. *Psychiatric Bulletin*, **25**, 121–123.

**Shaw, A. (1988)** *A Pakistani Community in London*. London: Blackwell.

**Social Exclusion Unit (2000)** *Minority Ethnic Issues in Social Exclusion and Neighbourhood Renewal*. London: Cabinet Office.

**Thornicroft, G., Rose, D., Huxley, P., et al (2002)** What are the research priorities of mental health service users? *Journal of Mental Health*, **11**, 1–5.

**Warr, P. (1987)** *Work, Unemployment and Mental Health*. Oxford: Oxford University Press.

**Watt, G. (2001)** Policies to tackle social exclusion. *BMJ*, **323**, 175–176.

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