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
to prevent people who develop a mental ill-
ness while in employment from losing their
jobs and progressing on to long-term bene-
fit, they would significantly reduce the eco-
nomic burden of social exclusion. One way
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 tem-
porarily 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 support-
ing the continuation of employment for
those who are temporarily unable to work.

SOCIAL EXCLUSION
AND INCOME

A major factor enabling people to partici-
pate in community leisure activities is their
income level. Studies have found that about
half the patients in contact with a com-
munity mental health service in England
were not receiving the full amount of wel-
fare benefits to which they were entitled
(e.g. McCrone & Thornicroft, 1997). Both
the inherent nature of mental health prob-
lems and discriminatory responses to them
have deleterious effects on interpersonal
relationships, leading to reduced social con-
tacts. 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 activ-
ities (Cattell, 2001). Psychiatrists may also
have a role here in establishing or support-
ing schemes which offer expert welfare ben-
efits 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 sig-
nificant contribution to the improvement

of ‘social quality’. This has been defined as
‘the extent to which citizens are able to par-
ticipate in the social and economic life
of their communities under conditions
which enhance their well-being and indivi-
dual 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, conse-
quences and outcomes of mental disorders,
both for the patient and for the commu-
nities 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.

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