Part 1

What is social exclusion?

CHAPTER 1

Introduction

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Social exclusion is a term of relatively recent origin which has come into use in the area of social policy and has particular relevance for people with mental health problems and learning disability (Office of the Deputy Prime Minister, 2004). It encapsulates the position of many people with mental health problems and learning disability in contemporary society, as well as summarising their position in history. This book sets out to outline the meaning of social exclusion, the ways in which people with mental health problems and learning disability are excluded, and the implications of this for the training and practice of psychiatrists (and, by implication, other mental health professionals) and the services in which they work. The book seeks to inform by examining and evaluating the nature of social exclusion and the ways in which people with mental health problems and learning disability are excluded. In the subsequent chapters we build up a picture of social exclusion of those people in Britain in the 21st century. This picture illustrates that social exclusion is an objective reality in their lives; it is reflected in their own subjective experiences and is open to the independent scrutiny of health professionals.

In this book we set out a case for why social exclusion should be of concern to psychiatrists and others working in mental health services and why these services should be designed to be 'socially inclusive'. The nature of social exclusion and its relation to ill health makes it a legitimate concern to mental health professionals. However, this is only one of several possible standpoints from which the significance of social exclusion to mental health professionals can be assessed, which in turn raises the matter of professional values. A stream of possible actions follows from these concerns. How might the exclusion of people with mental health problems and learning disability be diminished? How might their participation in mainstream society be increased? What is the role of mental health services and mental health professionals in this? What are the implications for the training and practice of professionals, and the organisation, delivery and culture of mental health services? Finally, what should be the role of mental health professionals in influencing policy and public opinion?

This chapter introduces the concepts of social exclusion and inclusion, their importance for people with mental health problems and those with learning disability, and their relevance to professional practice and mental health services in the 21st century.

A note on terminology

Finding an acceptable summary term to describe the range of people with psychiatric diagnoses is fraught with difficulty. As this book was based on the Scoping Group on Social Inclusion review, the same range of diagnoses as was included in that review are represented here (see Preface).

In this book we emphasise the importance of regarding individuals who have a psychiatric diagnosis as being first and foremost people, regardless of the nature of their problems or disability. We have chosen to use the term 'mental health problem' to summarise most of the diagnoses listed above. However, learning disability is not in itself a mental health problem, although people with learning disabilities do have increased rates of mental illness, behaviour problems and pervasive developmental disorders. To help keep this in mind we sometimes refer to this group separately. We also recognise that the term mental health problem covers a heterogeneous collection of diagnoses and groups of people with very different experiences of exclusion, and where these groups need to be singled out then specific diagnostic categories and terms are used.

Context: society and contemporary mental health services

The context for this book lies in the changes in UK society, and in the delivery of mental health services, that have occurred since the 1940s. Although there have been 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 has widened (Wilkinson & Pickett, 2009). Inequalities have increased and the numbers in relative poverty reached a historic high in the 1990s. There has been some subsequent fall in those figures, but a high proportion of children still live in poor families and the reduction of child poverty remains a key government target.

For many people the experience of poverty, although unpleasant, is relatively brief. However, about 2–4% of the population live in persistent poverty and for others poverty may be a recurrent experience (see Chapter 7). People with multiple disadvantages are most at risk of poverty and social exclusion. Those who are jobless, older people, single parents, long-term sick and disabled are overrepresented among those who are multiply disadvantaged, as are those with mental health problems and people with learning disabilities. People from Black and minority ethnic groups are

also more likely to experience social exclusion, especially if they are recent migrants or come from linguistically and/or culturally isolated groups.

There is little doubt that mental health services have changed, and in many ways improved, during the second half of the 20th century: the large institutions have closed and most services are now provided in a community setting. However, these arrangements are relatively new and it was only in the 1990s that the last large mental hospital closed in England and the first English national plan for mental services, the National Service Framework for Mental Health, was created (Department of Health, 1999). The evolution of mental health services during the 1990s was accompanied by an increasingly active and politicised disability movement, including people with mental health problems and those with learning disabilities, demanding not only improved services, but also equality, rights, participation and social and political action (Oliver, 1990; Sayce, 2000).

These three matters: the increasing demands of mental health service users and their families for just representation, their continuing exclusion from participating as full and active citizens, and the changing nature of mental health services are the main drivers behind the production of this book. There is no place for complacency and it is timely to examine the status and participation in society of people with mental health problems and those with learning disabilities and the ways in which the psychiatrists, other mental health professionals and services can respond to their social exclusion.

Social exclusion – old wine in new bottles?

Despite the relatively recent emergence of the term social exclusion, its origins are much older. Social exclusion is one way of conceptualising disadvantage, traditionally seen in terms of poverty, hardship, destitution, all of which focus on material deprivation and the consequent personal distress. These are matters familiar to people working in mental health services and will be encountered in their day-to-day practice. Efforts to improve the quality of life of service users have been seen as a legitimate role of mental health professionals and, historically, there have been notable attempts by professionals to counter the stigma, discrimination and injustice that are experienced by people with mental health problems and learning disabilities and to act as proponents for their human rights. This book therefore builds on much that we already know, but puts it in the context of current developments and the potential opportunities that face us.

Professional roles – healing and professionalism

The profession of medicine is changing. It is becoming more collaborative, with a greater emphasis on self-care and patient choice, and greater recognition of the contribution of patients as experts in their own conditions

(General Medical Council, 2006). This is reflected in the latest guidelines of *Good Psychiatric Practice* (Royal College of Psychiatrists, 2009*a*). Psychiatry has to face these challenges and each of the subspecialties will need to adapt its practice in different ways. In later chapters the idea of socially inclusive mental health services is discussed. The creation of these services, which will support individuals on their own unique journeys of recovery, represents a considerable challenge 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 existing skills, and adapt these to support socially inclusive practice and create new forms of relationships with service users and carers which are based on partnership.

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 people who experience health and personal difficulties as anyone else might, and who may 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 traditional, biomedical model.

All the main mental health professional bodies have made explicit statements regarding social inclusion and mental health. The Royal College of Psychiatrists (2009*b*) has declared its position in regard to social exclusion and the importance of socially inclusive practice and has given clear support to the concepts of recovery (Royal College of Psychiatrists *et al*, 2007). Other mental health professional groups, including nurses, occupational therapists, clinical psychologists and social workers, have also indicated their support for socially inclusive and recovery-oriented practice (British Psychological Society Division of Clinical Psychology, 2000; College of Occupational Therapists, 2006; Department of Health, 2006; British Psychological Society Professional Practice Board Social Inclusion Group, 2008; Royal College of Nursing, 2009). The ideas of social exclusion and inclusion are fundamental to social work practice, which has traditionally occupied the space between the mainstream and the marginalised (Shepherd, 2006). Psychological therapists have often recognised the dilemma of working with individuals whose problems may be linked to wider social and economic factors, while leaving these wider factors unchallenged (Corey, 1991; Clark, 1993; Gordon, 1999). The way professionals work with excluded individuals, their social position, their empowerment and the effects of broader social, political and economic institutions are all legitimate concerns for mental health professionals.

What are the steps that psychiatrists and mental health workers can take to facilitate the social inclusion of people with mental health problems? Inevitably, many of the actions to be taken will go beyond those of individual practitioners and will involve changes at institutional, economic, political and social levels. Individually professionals may have a role in influencing these wider dimensions through the democratic process or through their

own jobs. Their professional bodies may use their influence in campaigning and lobbying at the national level. An example of such a campaign is the College's 'Fair Deal for Mental Health' (Royal College of Psychiatrists, 2008), which is concerned with many of the elements of social inclusion (Box 1.1).

Individual practitioners do have a role to play in their professional life in facilitating action in relation to these collective dimensions as an integral part of inclusive practice. They may act by advocating for people with mental health problems who they see in the course of their daily practice, or by utilising their other roles as, for example, managers, teachers and researchers.

Inevitably, the way in which psychiatrists and other mental health professionals may have to alter their practice to face the challenges of exclusion raises questions about their roles as professionals and as healers. Both of these roles overlap (Fig. 1.1) and both can be maintained and enhanced by consideration of what may constitute 'socially inclusive practice'. The physician's roles of healer and professional are linked through ethics and values as well as through science, including social and political science (Cruess *et al*, 2002), all of which are considered in subsequent chapters.

Box 1.1 Royal College of Psychiatrists' Fair Deal campaign principles

- People with mental ill health and learning 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 own potential to the full.
- People with mental ill health and learning 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 patients with physical illness in the general hospital setting.
- Discrimination against people with mental health problems and learning disability can be tackled throughout the NHS. 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 patients must be promoted and safeguarded. This applies particularly to those detained or deprived of liberty under mental health and mental capacity legislation.
- Healthcare to people with mental ill health and learning 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 has several components that explicitly relate to social inclusion (http://www.rcpsych.ac.uk/campaigns/fairdeal.aspx).

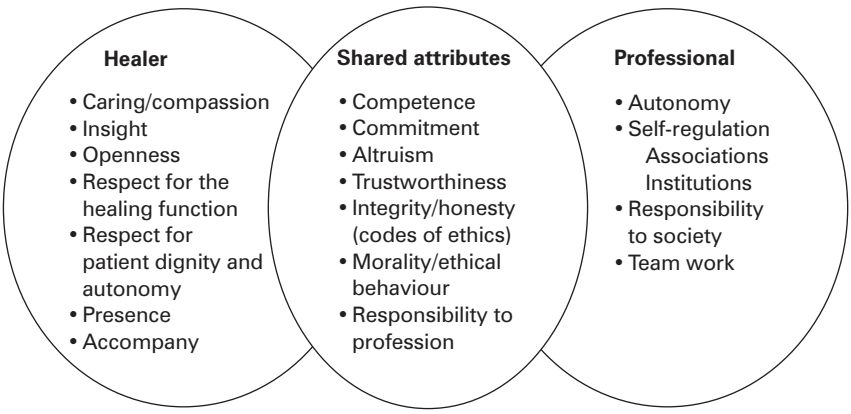

Fig. 1.1 Attributes of the healer and professional and their overlap. Adapted from Cruess & Cruess (2009), p. 13.

In addition to serving the best interests of the patient (by respecting patient autonomy and through viewing the doctor–patient relationship as a partnership), professionals have acquired an obligation to serve the wider society and be devoted to the public good, a form of 'civic professionalism' (Sullivan, 1995: p. 16; Cruess *et al*, 2002). At the individual level, the adoption of recovery-oriented practice (Shepherd *et al*, 2008) can enhance the healing role. The professional role may be strengthened through mental health workers and service users sharing a view of future mental healthcare at the same time as working to improve the rights and status of people with a mental disorder.

Summary

Social exclusion is one way of conceptualising disadvantage. It is not a new idea; it has its origins in the literature on poverty, hardship and destitution.

British society has changed during the 20th century, with improvements in the standards of living and quality of life. Nevertheless, a substantial number of people live in poverty and are socially excluded. The gap between rich and poor widened at the end of the century. Mental health services have also changed, becoming more community-based.

People with mental health problems and those with learning disabilities want to see improved health and social services and to have a greater voice in how these are run. They also seek greater opportunities for participation and emphasise the importance of equality and rights in promoting this.

Psychiatrists and other mental health workers can contribute to the social inclusion of people with mental health problems and learning disabilities and this is consistent with their professional roles and responsibilities.

References

British Psychological Society Division of Clinical Psychology (2000) *Recent Advances in Understanding Mental Illness and Psychotic Experiences*. British Psychological Society.

British Psychological Society Professional Practice Board Social Inclusion Group (2008) *Socially Inclusive Practice. Discussion Paper*. British Psychological Society.

Clark, C. R. (1993) Social responsibility ethics: doing right, doing good, doing well. *Ethics and Behaviour*, **3**, 303–327.

College of Occupational Therapists (2006) *Recovering Ordinary Lives: The Strategy for Occupational Therapy in Mental Health Services 2007–2017*. College of Occupational Therapists.

Corey, G. (1991) *Theory and Practice of Counselling and Psychotherapy (4th edn)*. Brooks Cole.

Cruess, R. L. & Cruess, S. R. (2009) The cognitive basis of professionalism. In *Teaching Medical Professionalism* (eds R. L. Cruess, S. R. Cruess & Y. Steinert). Cambridge University Press.

Cruess, S. R., Johnston, S. & Cruess, R. L. (2002) Professionalism for medicine: opportunities and obligations. *Medical Journal of Australia*, **177**, 208–211.

Department of Health (1999) *National Service Framework for Mental Health. Modern Standards and Service Models*. Department of Health.

Department of Health (2006) *From Values to Action: The Chief Nursing Officer's Review of Mental Health Nursing*. Department of Health.

General Medical Council (2006) *Good Medical Practice*. General Medical Council.

Gordon, P. (1999) *Face to Face: Therapy as Ethics*. Constable.

Office of the Deputy Prime Minister (2004) *Mental Health and Social Exclusion – Social Exclusion Report*. ODPM.

Oliver, M. (1990) *The Politics of Disablement: Critical Texts in Social Work and the Welfare State*. Palgrave Macmillan.

Royal College of Nursing (2009) *Socially Inclusive Practice for Nurses*. Royal College of Nursing.

Royal College of Psychiatrists (2008) *Fair Deal for Mental Health: Our Manifesto for a 3-Year Campaign Dedicated to Tackling Inequality in Mental Healthcare*. Royal College of Psychiatrists.

Royal College of Psychiatrists (2009*a*) *Good Psychiatric Practice (3rd edn)*. Royal College of Psychiatrists.

Royal College of Psychiatrists (2009*b*) *Mental Health and Social Inclusion: Making Psychiatry and Mental Health Services Fit for the 21st Century*. Royal College of Psychiatrists.

Royal College of Psychiatrists, Social Care Institute for Excellence & Care Services Improvement Partnership (2007) *A Common Purpose: Recovery in Future Mental Health Services*. Social Care Institute for Excellence.

Sayce, L. (2000) *From Psychiatric Patient to Citizen: Overcoming Discrimination and Social Exclusion*. Macmillan.

Shepherd, G., Boardman, J. & Slade, M. (2008) *Making Recovery a Reality*. Sainsbury Centre for Mental Health.

Shepherd, M. (2006) *Social Work and Social Exclusion: The Idea of Practice*. Ashgate.

Sullivan, W. (1995) *Work and Integrity: The Crisis and Promise of Professionalism in North America*. HarperCollins.

Wilkinson, R. & Pickett, K. (2009) *The Spirit Level: Why More Equal Societies Almost Always Do Better*. Penguin.