



## Community participation and social inclusion: How practitioners can make a difference

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### Abstract

People with mental disorders are marginalised and socially excluded from many aspects of community life. They often experience difficulty with obtaining employment, participating in community activities, affordable and sustainable housing, financial and legal issues, transportation, and limited information about, and access to, the options that are available to them. In this article, we describe a selected number of activities that promote social inclusion. Social inclusion not only offers us a framework for developing mental health policy, but serves to measure how well mental health services are achieving recovery-orientated outcomes. Examples are provided to highlight how the concept of social inclusion can be applied in the everyday practice of mental health practitioners.

### Keywords

*mental health, community participation, social inclusion, practitioners, recovery, consumer, psychiatric disability, employment*

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### Introduction

The desire to be accepted by other people is one of the most basic human needs. Social isolation or rejection is very stressful to anyone but particularly individuals with mental disorders. A member attending a psychosocial rehabilitation centre wrote:

*To have a mental illness in Western society is to be treated as an outcast... At times, trying to communicate with people who spoke too fast was difficult... Often people talk around me and not to me. They do not look me in the eye. I want to tell them I am a human being, too.* (Murphy, 1998, p. 185)

People who feel excluded or rejected often report deterioration in physical health and increased stress and anxiety. It has been argued that people with mental disorders are among the most

excluded in society. One may even say that schizophrenia, as one form of mental disorder, 'is the modern-day equivalent of leprosy' (Ertugrul & Ulug, 2004, p. 73). This article discusses strategies to promote the community participation and social inclusion of people with mental disorders.

### Social inclusion

Social inclusion involves being able to rejoin or participate in leisure, friendship and work communities. Inclusive communities provide equal opportunities for sharing power and resources amongst different people in society (Townsend, 1997). Connectedness and interdependence are fostered among community members by sharing values, beliefs and visions. Individuals not only meet their own needs but

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reach out to meet the needs of others. Community connectedness facilitates healing by joining people together, and attracting those who are outside the community.

Indicators of social inclusion include employment, housing, education, participation in leisure/ social activities, access to health services, health insurance, security/ welfare support and community services, regardless of people's cultural background, sexual orientation, gender or nature/ level of disability or other definable differences (Office of the Deputy Prime Minister [ODPM], 2004). Social quality refers to the concepts of social inclusion and also socio-economic security, social cohesion and empowerment. Social quality is 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 wellbeing and individual potential (Beck, van der Maesend & Walker, 1997). Social inclusion and social quality are maximised when a large proportion of the people of the country are granted full citizenship (Huxley & Thornicroft, 2003).

People with mental disorders are over-represented in all socially excluded groups, such as 'the poor', 'the unemployed', 'the homeless', 'the violent', 'the isolated', 'black and ethnic minority groups', in some cases 'the indigenous people' and various combinations of these and other categories (Bonner, Barr & Hoskins, 2002). Similarly, studies reported that employers, families of service users, mental health workers and prospective landlords all show discrimination against individuals diagnosed as having a mental disorder (Perlick, Rosenheck, Clarkin et al., 2001; Struening, Perlick, Link et al., 2001).

### **Recovery approach**

Two paradigms currently influence the modern mental illness/mental health landscape: the traditional medical model and the recovery approach. Following the medical tradition, diagnosis and assessment govern the interaction between doctor and service user. Diagnosis and treatment is based on deductive logic with precise empirical observations of individual behaviour and manifestation of symptoms. The

medical model seeks to discover and confirm a set of probabilistic causal laws that can be used to predict general patterns of human activity (Alloy, Acocella & Bootzin, 1996; Davidson & Neale, 1998).

The recovery approach is defined in the *Blueprint for Mental Health Services* in New Zealand (Mental Health Commission, 1998) as an alternative strategy for mental health professionals to focus on achieving wellness instead of just treating illness. For a person with experience of mental disorder, recovery is about his/her ability to live well in the presence or absence of one's mental disorder (or whatever people choose to name their experience). Each person with mental disorder needs to define for themselves what 'living well' means to them. Copeland and colleagues (cited in Mental Health Commission, 2000) describe recovery as:

*...a process and an attitude, not a place. It is about regaining what may have been lost: roles, responsibilities, decisions, potential and support. It is not about symptom elimination, but about what an individual wants in his/her life, how he/she can get it, and how others can help/support the individual to get there. It is about rekindling hope for a productive present and a rewarding future... Recovery is reclaiming the roles of a 'healthy' person, rather than living life as a 'sick' person. Recovery is about getting there. (p. 5)*

### **Strategies to promote social inclusion in a community**

Nash (2002) suggested four basic actions to promote social inclusion:

- work with services providers;
- form alliance with and educate public media;
- develop community initiatives; and
- reform legal framework.

Services providers here include not only mental health services, but also social welfare, supported accommodation agencies, vocational rehabilitation specialists and educational providers. Citizenship is a key concept within the notion of social inclusion. To fully realise citizenship, one may have to lobby the legal system to include legal rights and equal opportunities for people with mental disorder to obtain employment, access housing of their choice, enrol in education programmes or to

exercise their right to vote (Johnstone, 2001; Nash, 2002). All these require practitioners to look beyond a medical paradigm, which views the individual and their symptoms as the main focus of intervention. There is a need to foster individual, community, societal, and environmental qualities to increase social participation for individuals with psychiatric disability (Herrman, 2001). Townsend (1997, p. 153) summed up:

*To promote inclusiveness to any degree in mental health services is to promote change: either to shift mental health services towards a more social and less individualised model; or to develop new mental health services which are integrated with employment, housing, recreation, education, and virtually all aspects of community life.*

The United Kingdom based Social Exclusion Unit (ODPM, 2004), suggested that in order to break the social exclusion cycle, a number of key actions need to be undertaken. These include:

- addressing the attitudes and beliefs of health and social care services;
- promoting employment opportunities;
- supporting families and community participation; and
- addressing housing, financial and legal issues, transport, and information and access.

Table 1, which is broadly structured according to Nash's and ODPM's actions areas, provides an overview of the socially inclusive strategies that are explored in the following sections.

### ***Addressing attitudes and beliefs***

#### ***Low expectations and negative assumptions***

It is not just the general public that has stigma related beliefs toward people with mental disorders. Low expectations and negative assumptions among health and social services staff can inhibit recovery and progress towards social inclusion. The new agenda for mental health services, which focuses on recovery, provides an important opportunity to change current thinking and beliefs about people with mental disorders and their capacity to be socially included within community activities. The workforce needs to understand that discrimination can be as great a threat to recovery as psychiatric disability is, and must

address its own discrimination against people with mental disorders (Mental Health Commission, 1998). Rickwood (2004) summarised this issue by stating:

*A change of attitude among service providers is fundamental to working within a recovery orientation. Many service providers, particularly of clinical services, still hold outdated beliefs that a diagnosis of mental illness is a life sentence to an incurable condition that invariably will have only negative consequences for a person's life course. (p. 3)*

#### ***Recovery orientation***

There is preliminary evidence that mental health practitioners can improve their attitudes to be more recovery-oriented, at least in the short-term. The NHMRC funded Australian Integrated Mental Health Initiative (AIMHI), found significant increases in recovery oriented attitudes (e.g., 'recovery can occur even if symptoms of mental illness are present') and increased hopefulness regarding goal attainment amongst mental health workers immediately following two days of Collaborative Recovery training (Oades, Deane, Crowe et al., 2005). While practitioners may be amenable to more recovery-oriented attitudes, it is not clear whether they view their roles to extend to facilitating social inclusion goals at a community level.

#### ***Psychosocial rehabilitation***

We argue that it is important for mental health practitioners to consider setting specific targets for employment, housing, education or engagement in social activities. The promotion of social inclusion should be incorporated into every service users care plan. Programmes that routinely help provide employment, recreational activities and social integration for service users from the early stage of illness is particularly important (Warner & Mandiberg, 2003). It has been suggested that contemporary psychosocial rehabilitation that promotes community integration should focus on customised services and supports, consumer choice, skills training, supported employment, supported education, peer support, and social network development (Caspar, Oursler, Schmidt & Gill, 2002). At all times social inclusion practice should be driven by consumer needs and goals.

**Table 1. Four key strategies to improve social inclusiveness for people with mental illness**

<b>Overarching principles</b>			
<ol style="list-style-type: none"> <li><b>1. Involve multiple services providers</b></li> <li><b>2. Form alliance with and educate public media</b></li> <li><b>3. Develop community initiatives</b></li> <li><b>4. Reform legal framework</b></li> </ol>			
<b>Specific actions for mental health practitioners</b>			
<b><i>Addressing attitudes and beliefs</i></b>	<b><i>Promoting employment opportunities</i></b>	<b><i>Supporting families and community participation</i></b>	<b><i>Addressing housing, finances, transport and access issues</i></b>
<ul style="list-style-type: none"> <li>• believe in service users' potential to recover</li> <li>• allow service users to take calculated risks to move forward</li> <li>• examine staff's own discrimination against people with mental illness</li> <li>• set specific targets for employment, housing, education or engagement in social activities in local community</li> <li>• social integration must be set as priority goal from early stage of intervention planning</li> <li>• think laterally to create multiple options for service users</li> <li>• psychosocial programme must have strong relevancy to service users' community lives</li> </ul>	<ul style="list-style-type: none"> <li>• adopt social disability and access model</li> <li>• develop a range of training and employment options in the local area</li> <li>• provide supported education</li> <li>• provide transitional and continuous supported employment</li> <li>• deal with the issue of disclosure of psychiatric disability</li> <li>• lobby changes in funding system to remove disincentive to work or offer paid jobs</li> <li>• provide alternative option such as workers' cooperatives</li> </ul>	<ul style="list-style-type: none"> <li>• family members or care-givers need support to encourage service users' community participation</li> <li>• psychoeducation as evidence-based practice</li> <li>• form partnership between mental health services and community organisations to develop joint social/ recreational initiatives</li> <li>• follow systematic process to plan and implement community-based programme</li> </ul>	<ul style="list-style-type: none"> <li>• provision of supported housing</li> <li>• links between housing, mental health services and support services</li> <li>• developing memoranda of understanding between mental health services and services providing supported housing</li> <li>• utilising practical strategies (e.g. paying rent and bills)</li> <li>• providing life skills training</li> <li>• advocacy</li> <li>• linking in with social support networks</li> <li>• developing money management skills</li> <li>• providing opportunities for community access</li> <li>• transport training</li> </ul>

Psychosocial rehabilitation activities must be associated with real life situations or challenges. Most mental health rehabilitation programmes consist of sessions or activities, which 'simulate' real life, such as social skills training, shopping for meals preparation, watering plants, cooking skills, or interview skills training. These simulated 'skills building' sessions are necessary but not sufficient to promote inclusive employment, recreation, and other community practices. Studies have demonstrated that these institution-based, simulated programmes at best appear to have only modest and short-lived effects on service users' feelings of mastery and perception of acceptance; at worst, some clients did not see programmes being relevant to their return to community (e.g., Townsend 1997; Wright, Gronfein & Owens, 2000). Opportunities to utilise skills in community contexts are essential. An emphasis on systematic between-session practice (homework) will likely improve the transfer of institution-based learning to real life community contexts. There is a modest but growing research base to support the effectiveness of homework in therapy (e.g., Glaser, Kazantzis, Deane & Oades, 2000; Kazantzis, Deane & Ronan, 2000).

### ***Promoting employment opportunities***

#### ***Employment***

The employment level of individuals with psychiatric disability is between 10% and 15% in most English speaking countries like the United States, United Kingdom, and Australia. However, it has been reported that 60-70% of people with psychiatric disability would like to be in paid employment (Huxley & Thornicroft, 2003; Warner & Mandiberg, 2003). A low level of employment does not have to be inevitable. For instance, employment of people with severe psychiatric disability in northern Italy is considerably higher, at between 50% and 60% with about a quarter in full-time employment (Warner, de Girolamo, Beelli et al., 1998). One possible explanation for such a difference in employment rates is the variety of work opportunities created by vocational programmes and the socially inclusive environment created by the welfare system. Socially inclusive work practices may involve offering paid jobs to

people recovered from mental disorders, or temporarily limiting the scope of responsibility. Furthermore over the last decade, evidence has been accumulating to support the effectiveness of supported employment as a form of vocational rehabilitation for mental health service users (e.g., Morris & Lloyd, 2004).

#### ***Supported employment***

Strong evidence about the effectiveness of the supported employment model has gathered over the last 10 to 15 years (Bond, 2001). The common characteristics of supported employment are: competitive employment is the goal (not day treatment); rapid job search and placement; integration of vocational rehabilitation and mental health services; attention to the person's preferences, work skills and experiences, continuous assessment and ongoing support by an employment consultant or case manager (Morris & Lloyd, 2004). In order to approach a 70% success rate for people obtaining and sustaining competitive employment, mental health services also need to have a trained person(s) who is responsible for supporting the person with disability's social inclusiveness in work activities.

#### ***Work skills***

One of the first challenges for this worker is to increase the consumer's chance of being considered as a potential candidate for a job. Often this requires a two-tier approach. Firstly, the person with disability will benefit from coaching on job interview skills. The coaching on interview skills supports the person in their decision about whether they will disclose their mental disorder and/or ongoing psychiatric disability. The current research on this topic suggests that it is not simply about disclosing or not, it is how the background and experiences are being presented and discussed during the interview (for discussion, see Waghorn & Lewis, 2002). Secondly, employment specialists together with service users need to lobby policy makers and funders to address the remaining disincentives for prospective employers to offer paid work or for service users to work at all in the income support/ benefit systems (Evans & Repper, 2000). There are also other viable options to enhance employment rates among

service users such as social firms or worker cooperatives employing people with mental illness (Warner & Mandiberg, 2003).

### ***Collaborative practice***

The Illawarra Mental Health Integration Project, funded by the Australian Department of Health and Ageing, included Community Development Officers (CDOs) who worked actively with rehabilitation services (Social Policy Research Centre, 2003). The CDOs brought together employment services, education providers, employers and service users. Their approach included assessing needs of services users who could be linked into mainstream community activities, combating community (employer) stigma, the development of protocols that outlined the responsibilities of various parties (e.g., support provided by the mental health service while the service user was employed), and actively supporting organisations that extended or enhanced their services to mental health consumers. The evaluators of the project indicated that the CDOs 'considerably enhanced the rehabilitation options for consumers in setting up agreements between consumers, their rehabilitation key workers, providers and employers, that have created pathways for consumers leading towards recovery and community integration' (Social Policy Research Centre, 2003, p. 101).

### ***Supporting families and community participation***

#### ***Psychoeducation***

Family members involved in the care of relatives such as children or parents with a mental disorder often provide emotional support, transport, financial help and housing for their relative. They need ongoing and good quality support to help maintain their family members' tenancy and social integration in the community. Psychoeducation groups or programmes for family members typically include a core set of components including: provision of emotional support, education, development of resources and coping skills during periods of crisis, and problem-solving skills. Research conducted over the past decade has shown that family members who attend such psychoeducation groups have gained more knowledge, changed their attitudes

towards the patients, enhanced their coping skills and report less burden related to caring for their relative with mental illness (Anthony & Spaniol, 1994; Dixon, McFarlane, Lefley et al., 2001; Spaniol, Gagne & Koehler, 1997).

#### ***Social support***

Ways to promote and foster consumers' community participation might involve forming partnerships between mental health services and community organisations (e.g., local volunteer services, clubs, art centres and sport centres). Mental health practitioners who support goals related to social inclusion extend their role from a focus exclusively on providing direct therapeutic interventions with a 'patient' to working with community based services in order to provide social support for people with mental illness. Social support has been associated with good health, well-being and functional performance of individuals with psychiatric disability (Edmonds, Mosley, Admiraal et al., 1998; Keck, McElroy, Strakowski et al., 1998; Michalak, Wilkinson, Hood et al., 2003).

Social support generally refers to help that is provided by one's family or friends that facilitates the individual's ability to cope with stressful life events. It has an element of intimacy, and an opportunity for reciprocal and socially motivated behaviors (Berkman, 1995). However the question of whether and in what form social support may be available is of particular importance for individuals with mental disorders because their social networks are at greater risk due to factors such as the stigma, difficulties with social skills, the presence of socially undesirable behaviors when the person is unwell, and/or other social sequelae wrought by the illness (e.g., financial hardship, unemployment, loss of life roles). Traditional approaches to improving social inclusiveness by training individual's social skills, assertive skills or provision of peer support groups are not the solution for every mental health service user. There are innovative community-based projects which achieve the same goal but without focusing on the person's deficits.

#### ***Community and cultural development***

The Victorian Health Promotion Foundation (VicHealth) aims to promote health and

wellbeing through community and cultural development. Their work is informed by an emerging evidence base, which indicates that communities with high rates of participation by individuals in community activities have better health outcomes than those with low levels of civic engagement (McQueen-Thompson & Ziguras, 2002). Community arts projects may include activities such as, choral performances, theatre, concerts, murals, film, photography, festivals and education programmes. Indicators of value of such programmes have been described as social, educational, artistic, and economic. Participation in arts and creative activities is often facilitated by psychosocial rehabilitation practitioners through mental health settings, but less has been done to support people taking up activities in mainstream settings (ODPM, 2004).

How do we go about developing community projects to promote service users' community participation? Raeburn (1992) suggested an eight-step framework to develop and implement a community project:

- set specific aims, objectives and scope for the community development project;
- conduct needs and wishes assessment involving all key stakeholders including service users;
- perform contextual analysis in terms of, who will be the funders, power structure within relevant organisations, community groups or individual readiness to be engaged in the project;
- plan the project to include specific time lines with key milestones;
- develop action components outlined personnel involved and resources required;
- proceed with full implementation;
- conduct periodic review and formative assessment; and
- perform outcome and process evaluation.

By following Raeburn's suggestions, practitioners will be well able to develop community projects, which support consumers to be involved in socially inclusive activities.

### ***Addressing housing, financial and legal issues, transport, information and access***

#### ***Housing***

With regard to housing, it has been shown that a label of mental disorder makes it difficult to find accommodation. For example, a study in the United States found that 40% of landlords immediately rejected applicants with a known mental disorder (Alisky & Iczkowski, 1990; Page, 1977). In meeting basic necessities of life it is important to focus on three priority areas (Bonner et al., 2002):

- where to live (safety for others and self, access to accommodation benefits, enough money for food and able to look after oneself);
- something to do (paid employment, education, purposeful day-time activities, enough money, access to telephone and internet, transport); and
- formation of meaningful and fulfilling interpersonal relationships.

As stated by the Social Exclusion Unit, stable and appropriate housing is critical for people to work and take part in community life (ODPM, 2004). People with psychiatric disability are particularly vulnerable to problems with housing, such as uncertainty with length of tenancy, substandard accommodation, rent arrears, and threat of eviction. The preferred approach to housing for people with psychiatric disability has increasingly been the use of supported housing (Rog, 2004). This type of accommodation arrangement enables people with psychiatric disability to live in the community and receive flexible, individualised services depending on the person's needs and choices. Supported housing is linked with the provision of mental health and support services. In a review of the evidence base for supported housing, Rog (2004) found that the studies indicated significant improvements in residential outcomes for people with psychiatric disability. Little evidence was found in support of any specific form of supported housing or what organisational approaches work best for delivering supported housing.

Given the scarcity of affordable housing, it is important that practitioners explore ways of maximising the housing stock that is available. This requires non-government organisations who provide the bulk of supported housing services to work closely with government departments and mental health services. Similarly, there is a need for good communication between government services. An example of one strategy to support these working relationships is for local mental health services to develop memoranda of understanding with the Department of Housing. Such agreements specify issues such as access, assessment, availability of mental health providers should disputes arise and the structures and procedures for resolving difficulties. Practitioners may need to address practical issues such as ensuring that the rent and bills are paid and that the person is assisted with life skills in order to maintain the accommodation.

Roder et al. (2001) provided evidence that structured and systematic skills training was more effective than other means of delivering psychosocial interventions. They described the social skills that are relevant for day-to-day-living, for example the ability to independently make telephone calls about housing and being able to write a letter of application for housing. Ongoing monitoring of mental health status is an important consideration in preventing relapse which may impact on a consumer's tenancy. Practitioners may also need to undertake an active advocacy role to resolve housing-related crises.

#### ***Financial and legal issues***

Financial difficulties, such as being in debt, not receiving the correct entitlements, and having problems managing money are common amongst individuals with psychiatric disability (ODPM, 2004). Practitioners may need to work with consumers on financial issues such as, how they feel they are managing their money, whether they have a budget, whether short term and long term expenses have been determined, how confident they are with accessing banking services, and whether they need support in filling out forms and with accessing government assistance. People with psychiatric disability also tend to experience difficulty with legal issues

and with accessing the same legal protection as other people in the community (ODPM, 2004). Practitioners typically need to take a proactive role in linking people in with advocacy services. For example, people who have come into conflict with the law may be expected to undertake community service. In such circumstances there would be a need to explore the best ways for the person to carry out community service in a supportive environment, such as participating in a gardening project conducted by the rehabilitation programme. This type of approach needs the development of an active collaboration with the appropriate government department.

#### ***Transport***

Access to many of the activities to promote social inclusion in the community relies on the availability of transport. This is an important consideration in providing supported housing and locating services and supports in the community. In short, it is preferable to have people housed in a location with access to affordable transport that will get them to community-oriented activities such as work or leisure activities. Even with access to affordable transport, further support is often needed in being able to use it appropriately. This may involve addressing unfamiliarity with transport routes, bus schedules, or lack of confidence in travelling by public transport. It may be necessary for the health practitioner to provide practical assistance in developing the necessary skills to enable the person to use transport independently. This may include teaching skills to access bus timetables, practice in reading the timetable and determining the appropriate route to get to community based activities and having a graded approach in practising catching and travelling on the bus.

#### ***Information and access***

People living in supported housing often need to be linked in with local support networks to give them something meaningful to do during the day and to decrease the social isolation that may be experienced. This is particularly important given considerable variation in structured active leisure opportunities that are offered across different supported accommodation services. Meaningful

activity has been found to have a positive impact on people's lives with respect to their loneliness, self-esteem, social functioning, satisfaction with social relations, leisure activities and general life satisfaction (Petryshen, Hawkins & Fronchak, 2001). People with psychiatric disability need both, information about the options that are available to them and support to access these opportunities (ODPM, 2004). Part of the support to access these opportunities may be financial in nature.

## Conclusion

There are many opportunities for mental health service providers to facilitate social inclusion of individuals with mental disorders. In some cases being ready for these opportunities requires a willingness to shift to a more recovery-oriented approach and a recognition that one's role may need to move toward working with families, community organisations, employers, educational institutions or a range of other groups. Many of the strategies suggested to increase social inclusion interact with each other and will need simultaneous implementation. Together they substantially increase the probability that individuals with psychiatric disability will experience greater social inclusion.

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