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All human beings are born free and equal in dignity and rights.

Article 1, United Nations Declaration on Human Rights
Introduction

Social inclusion and mental health

In recent years social inclusion/exclusion has emerged as a prominent concept in discussions about social disadvantage. While the link between disability and exclusion has been well documented over the past decade, what has become increasingly well understood, especially through research carried out in the United Kingdom and Europe, is the impact of exclusion on people with mental health problems. Adults with mental health problems are said to be one of the most excluded groups in society. Exclusion impacts on people's ability to enjoy and function in their lives and communities and their ability to both get and stay well.

In New Zealand, there has been no in-depth study in the area of mental health using a social inclusion lens, although, there has been research undertaken on discrimination which is often linked to issues of inclusion. The research carried out by the Mental Health Foundation of New Zealand and Like Minds, Like Mine and reported in Respect Costs Nothing (2004) tells us that experiences of discrimination are common among people with experience of mental illness. People with mental health problems report discrimination in all aspects of their lives from employment and housing to discrimination from friends and family and the community. The effect of this discrimination is that people with mental health problems often feel excluded from many activities of daily living. The research also indicates through qualitative means that discrimination appears to be embedded within systems via policies and procedures.

The purpose of this paper

This paper presents the findings of the Mental Health Commission's 08/09 project on social inclusion. The purpose of the paper is to foster discussion around the issue of social inclusion for people with mental health problems. It is primarily aimed at promoting discussion within the Mental Health Commission and amongst the Multi-agency Anti-discrimination Plan group (MAP) although it may be useful to others who are involved in promoting inclusion for people with mental health problems.

The paper explores the concept of social inclusion, the benefits and possible limitations of using a social inclusion paradigm and the issues that need to be addressed in developing a measuring framework.

This paper responds to the following issues:

- What is meant by social inclusion?
- Is social inclusion worth measuring for people with mental health problems?
- If so, how can it be measured?

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1 This was reported to be the case in the United Kingdom in the 2004 Social Exclusion Unit Report.
2 The MAP group is a group of agencies who work together to reduce discrimination and promote social inclusion for people who experience mental illness. The members are the Human Rights Commission, the Mental Health Foundation of New Zealand, Like Minds, Like Mine (of the Ministry of Health), the Office for Disability Issues (of the Ministry of Social Development) and the Mental Health Commission.
Appendix One sets out a proposed framework for measuring social inclusion for people with mental health problems in New Zealand.

Note, the concepts of social inclusion and exclusion are closely related, and it is difficult to discuss social inclusion without also discussing social exclusion. Throughout this paper, the discussion switches between social exclusion and inclusion as two ends of a single dimension.

Mental Health Commission 08/09 project

The aims of the Mental Health Commission's 08/09 project on social inclusion were to conduct a conceptual review of social inclusion, focusing on the origins and definitions of the concept and then on approaches to measurement, both in general and in relation to mental health.

The Mental Health Commission (the Commission) has undertaken this work for two reasons:

1. Monitoring the implementation of the mental health strategy
   The Commission has been working on the development of a monitoring framework designed to ensure systematic and useful feedback on the implementation of the national mental health strategy. This will fulfill the Commission's statutory monitoring function. The emphasis of the Commission's monitoring and advocacy work will be on reducing stigma and discrimination and ensuring quality services and effective funding.
   The Commission's work on conceptualising and measuring social inclusion will feed into the monitoring framework.

2. MAP project to measure social inclusion
   The MAP group is considering whether to measure and report on social inclusion for people who experience mental health problems as part of its joint anti-discrimination work. This paper aims to develop further the work that has been undertaken to date. Phoenix Research, on behalf of Like Minds Like Mine (LMLM), has undertaken research to identify options for measuring changes in the extent of social inclusion and rates of discrimination against people with mental illness. The report, entitled Monitoring Changes in Discrimination and Social Inclusion Experienced by Persons with Mental Illness (2009), primarily focuses on showing the possible sources of discrimination and the methods of data collection that could be used to obtain information. This paper is similarly focused. It aims to situate Phoenix Research’s work within a broader conceptual and measurement framework.

Literature review

This paper is informed by an unpublished review of literature and conversations with key people.

There is a substantial body of literature that focuses on aspects of social inclusion for people with mental health problems. It is interesting to note that the concept of social inclusion has become an increasingly popular concept to use when focusing on issues of disadvantage. Studies on specific areas such as unemployment, housing, and education, are increasingly
reported as studies of social exclusion, and studies of interventions designed to improve aspects of people’s lives are described as programmes to promote social inclusion (Morgan, 2007).

Despite its popularity, social inclusion is rarely defined. There have been some studies that specifically look at social inclusion and mental health. Most notably, the United Kingdom’s Social Exclusion Unit report (2004) on Social Exclusion and Mental Illness summarised key findings relevant to each of the dimensions of social exclusion which were identified as including stigma and discrimination, employment, education and housing.

There are also several reviews of specific aspects of social exclusion and mental health, such as unemployment. This paper, however, does not look at the literature in each of the domains of exclusion. The purpose of the project was to review literature relating to the concept and measurement of social inclusion, both in general and in relation to mental health.
Conceptual Background

What is meant by social inclusion?

Social inclusion means many things to many people. In order to understand what the concept may mean to people who experience mental health problems, and how it may be used for policy and research purposes, there is a need to consider how the concept has been used to date.

Social exclusion is a relatively recent concept. It became increasingly adopted in official policy frameworks throughout Europe during the 1980s and became prominent in the United Kingdom following the election of the Blair Government in 1997, which set up a Social Exclusion Unit. The Social Exclusion Unit took a whole-of-government approach and used social exclusion as a broad concept to capture the consequences of material deprivation across the whole population in terms of restricted opportunities to participate in social and cultural activities (Levitas 2006). Later work focused on specific populations considered particularly vulnerable to exclusion, including people with mental health problems.

The Social Exclusion Unit’s Mental Health and Social Exclusion report in 2004 was a comprehensive report which identified five main reasons why mental health problems too often lead to and reinforce social exclusion:

- **Stigma and discrimination** against people with mental health problems is pervasive throughout society. Many people fear disclosing their condition, even to family and friends.

- Professionals across sectors too often have **low expectations** of what people with mental health problems can achieve. Employment is not seen as a key objective for people with mental health problems by many health and social care professionals.

- The **lack of clear responsibility** for promoting vocational and social outcomes for adults with mental health problems. Services do not always work effectively together to meet individual needs and maximise the impact of available resources.

- People can **lack ongoing support to enable them to work**. People on benefits often do not believe they will end up financially better off if they try to move into work. Many people lose jobs that they might have kept had they received better support.

- People face **barriers to engaging in the community**. They can struggle to access the basic services they need, in particular decent housing and transport. Education, arts, sports and leisure providers often are not aware how their services could benefit people with mental health problems and how they could make their services more accessible for this group. Many people do no want to participate in activities alone, but feel there is no one they can ask to go with them. People can also face exclusion by law from some community roles such as jury service.

Australia has followed the United Kingdom’s approach with the recent establishment in 2007 of the Social Inclusion Unit in the Department of the Prime Minister and Cabinet. The Unit has published a set of aspirational **Social Inclusion Principles** (2008) for Australia.

New Zealand has not followed suit in setting up a separate body to focus on inclusion issues, although the Government’s vision has been stated in Opportunity for All New Zealanders (p11) as:
An inclusive New Zealand where all people enjoy opportunity to fulfil their potential, prosper and participate in the social, economic, political and cultural life of their communities and nation.

While the Ministry of Social Development is the lead agency for promoting an inclusive approach in policy development, the mental health sector also has a part to play. The Government’s national mental health and addiction plan, Te Tāhuhu – Improving Mental Health 2005-2015, The Second New Zealand Mental Health and Addiction Plan (2005) states that mental health services need to recognise that a wide range of social and economic factors impact on people who have a mental illness or an addiction. Housing, employment, income and education are all important in ensuring people with mental illness are included in society and supported in their recovery.

**Definitions**

There are many definitions of social inclusion in the broader literature. Some of the most popular ones are:

- A shorthand label for what can happen when individuals or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown (Social Exclusion Unit 1997).

- Social exclusion is a complex and multi-dimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in society, whether in economic, social, cultural, or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole (Levitas et al 2007).

- An individual is socially excluded if a) he or she is geographically resident in a society but b) for reasons beyond his or her control, he or she cannot participate in the normal activities of citizens in that society, and c) he or she would like to participate (Burchardt et al 1999).

- Social inclusion can be defined in terms of the success of one or more of the following four systems of ‘integration’:
  - the democratic and legal system which promotes civic integration;
  - the labour market which promotes economic integration;
  - the welfare state system promoting social integration; and
  - the family and community system, which promotes interpersonal integration (Commins 1993).

‘One’s sense of belonging in society depends on all four systems. Civic integration means being an equal citizen in a democratic system. Economic integration means having a job, having a valued economic function, being able to pay your way. Social integration means being able to avail oneself of the social services provided by the state. Interpersonal integration means having family and friends, neighbours and social networks to provide care and companionship and moral support when these are needed. All four systems are therefore important. In a way the four systems are complementary: when one or two are weak the others need to be strong. And the worst off are those for whom all systems have failed’ (Commins 1993: 4).
While, definitions of social inclusion/exclusion differ in various respects, some of the key characteristics in common can be summarised as follows:

- Social exclusion is caused by an act or omission of some individual, institution or group.
- Social exclusion may happen where a person excludes themselves by choice or the person may be excluded by the decisions of other people, organisations or institutions.
- Social inclusion is relative to a given society (place & time) and is based upon a given society’s norms.
- Social exclusion is multi-dimensional (ie. it affects various life domains such as low income, poor housing and isolation).
- Social inclusion is dynamic (ie. people’s level of participation will vary over time).
- There are multi level causes of exclusion (ie. at the level of the individual; household; community and wider society).

A simple way of defining social inclusion for people with mental health problems, therefore, may be:

> Social inclusion is the extent to which people are able to exercise their rights and participate, by choice, in the ordinary activities of citizens in the society in which they reside.

**Underlying concepts: Rights and participation**

The literature indicates that there are two main approaches to thinking about social inclusion: (1) rights, and (2) participation (Huxley et al 2006). Both approaches are important and should inform a measurement framework.

**Rights**

A rights-based approach to social inclusion says that exclusion results when people are deprived of their citizenship rights. Citizenship refers to the possession by members of a community of a range of civil, political, economic, social and cultural rights by virtue of their membership in that community. The rights that citizens are entitled to are reflected in human rights instruments that form part of international law as well as being embodied in domestic legislation. A key right is the right not to be discriminated against.

The United Nation’s concept of a socially inclusive society as it relates to people with mental health problems is reflected most recently in the United Nation’s Convention on the Rights of People with Disabilities (CRPD). This convention sets out the entitlements of people with disabilities under international law, including people who have mental impairments. In addition to civil and political rights, the treaty embodies economic, social and cultural rights which in effect, require governments to make sure people with disabilities can access services and participate in society on an equal basis with others. Governments are required to ‘progressively realise’ these rights over time in accordance with resource availability.
The New Zealand government has an obligation to monitor the implementation of the CRPD and is in the process of setting up a framework. It is important from a mental health perspective to ensure that any reporting to the United Nations on the CRPD reflects accurate levels of inclusion for people with mental health problems.

Huxley et al (2006) have said that a rights-based understanding of social inclusion may be particularly important in the context of mental health, since a denial of rights and/or access to the means to realise entitlements has historically been a feature of the treatment of people with mental illness. This particularly relates to the implementation of civil and political rights in that people's rights may be denied via compulsory treatment provisions under mental health legislation. It also relates to rights such as the right to be treated with dignity and respect and to exercise autonomy wherever possible, whether the treatment is administered on a voluntary or involuntary basis.

It may be particularly important therefore, to ensure that any measurement framework adequately captures whether people's rights are being upheld, and whether there is adequate access to complaints and/or review processes.

**Participation**

A participatory approach to social inclusion focuses on the degree to which the individual identifies and participates in the wider social environment, and the access to resources that enables a person to enjoy a standard of living and well-being that is considered normal in the society in which they live. In order to do this, the approach involves identifying key functions or activities which are generally considered to be of value in the society in question, for example, work or socialising with friends.

The participation approach reflects the traditional concerns of social science and especially social policy, with measuring poverty and multiple deprivations (Huxley et al 2006: 10). Analysis based on participation rates will be especially important where comparisons with the general population are sought. Such comparisons may be useful in quantifying inequalities.

**Concepts overlapping with social inclusion**

Another consideration in understanding what is meant by social inclusion is how it overlaps with other concepts.

**Poverty**

Some definitions of poverty appear indistinguishable from social exclusion. However, some commentators have argued that social exclusion is a broader, more holistic understanding of deprivation, in contrast to poverty, which they see as ‘exclusively economic, material, or resource-based’ (Silver and Miller 2003).

Conceptualising social inclusion as being wider than poverty may be particularly relevant to mental health. The loss of roles, meaningful relationships and discrimination that both precede and

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3 The Office for Disability Issues is the lead agency for developing the framework.
accompany mental health problems do not necessarily stem from a lack of material resources (Morgan et al 2007). Rather, negative societal attitudes and response towards those with mental health problems can powerfully affect their social experiences and often result in a sense of social rejection and isolation (Link and Phelan 2004; Sayce 2001).

**Social Model of Disability**

A social model of disability is one where individuals with impairments are considered to be disadvantaged by social and environmental barriers to participation and, thus, they are disabled (Office for Disability Issues).

Sayce (2000, 2001) linked the concept of social inclusion with the social model of disability, arguing that many of the apparent social impairments experienced by those with mental health problems are a function of societal responses. From this perspective, the social inclusion of people with mental health problems can be achieved only when society changes. Here, the focus is on those doing the excluding rather than on the excluded, a perspective further reflected in the work of Repper and Perkins (2003), who considered social reintegration to be a key component of recovery from mental health problems (Morgan et al 2007).

**Recovery**

Social inclusion is also related to the concept of recovery which has gained increased attention in the field of mental health over recent decades, although, as of yet, there is limited consensus on how to conceptualise it. The Mental Health Commission has defined recovery as ‘living well in the presence or absence of mental illness’; however, the term is being used in a number of ways by the mental health sector, including as a way to describe an individual’s personal journey as well as a way to describe and evaluate mental health services. Researchers, in particular, are keen on defining recovery in order to measure the effectiveness of recovery oriented services.

Lloyd et al (2008) provide one approach that may be useful in positioning social inclusion within a broader framework of recovery. Lloyd et al’s recovery framework includes five inter-related domains:

- **Clinical recovery** and access to health care
- **Personal recovery**: a personal journey to reclaim empowerment, identity and purpose
- **Social recovery**: to restore social networks, reduce stigma, restore leisure activities and increase social inclusion in the wider community
- **Economic recovery**: to reduce poverty and improve standard of living (housing, income support)
- **Functional recovery**: to restore functioning in socially valued roles (worker, student, care or parent, self development, independent living).

In the context of this framework, social inclusion is included under the domain of ‘social recovery’ although ‘economic recovery’ and ‘functional recovery’ are also closely interrelated to a person’s ability to participate and claim citizenship rights.

It is important to note however, that not everyone agrees that the concept of social inclusion fits well within a recovery framework. Some argue that the recovery paradigm is inherently linked to
the medical model and is limited by a focus on individual pathology. Supporters of this view reframe mental health needs within a broader social notion of disability in which the focus is taken off individuals’ impairments. Instead, it is society that is challenged to change and evolve to include all people, regardless of difference.

**Well-being and quality of life**

Wellbeing is a similar concept to social inclusion although, like social inclusion, wellbeing remains a contested concept, enjoying a wide variety of definitions (McAllister 2005).

The terms ‘life satisfaction’, ‘happiness’, ‘quality of life’ and ‘wellbeing’ are often used interchangeably. Veenhoven (1997) describes quality of life as ‘the presence of conditions deemed necessary for the good life, and the practice of good living as such’. Huppert et al. (2004) defines wellbeing as ‘a positive and sustainable state that allows individuals, groups or nations to thrive and flourish’. This means at the level of an individual, wellbeing refers to psychological, physical and social states that are distinctively positive.

Keyes (2002) makes the distinction between subjective well-being made up of the individual’s ‘positive feelings’, and societal engagement and fulfilment which focuses on aspects of ‘positive functioning’.

Therefore both concepts of social inclusion and wellbeing have a focus on whether an individual is engaging or participating in aspects of life that society collectively agrees is important for a person’s happiness, quality of life and welfare. Indicators of social inclusion can potentially be useful in assessing a person’s overall sense of wellbeing.

**Discrimination**

There is a strong connection between discrimination and social inclusion. The difference may be understood by considering what gives rise to each one.

Discrimination occurs when a person is treated differently (and unfavourably) from another person in the same or similar circumstances. Discrimination can be direct or indirect (Human Rights Commission).

Direct discrimination can be described as ‘prejudice in action’ where ‘prejudice refers to a negative or hostile attitude toward another group, or an individual taken to be representative of another social group. It is based on a faulty and inflexible generalisation (literally, a “pre-judgement”)’ (Bromell and Hyland 2007).

Indirect discrimination may occur when an action or policy that appears to treat everyone the same way, actually has a discriminatory effect on a person or group of people (Human Rights Commission).

Social inclusion focuses on whether a person is able to exercise his/her rights and participate in the everyday activities of life. From this perspective, discrimination can be seen as one of the barriers to inclusion. However, there may also be other barriers to inclusion such as the effect of a mental impairment, lack of support or self-stigma. Exclusion may also be caused by cumulative actions, behaviours, prejudices and oversights which are often too complex to be identified as discrimination but are more likely to be picked up under a social inclusion analysis.
There may also be differences in the way social inclusion and discrimination are measured. Discrimination is typically measured from a person’s subjective perspective of whether an individual's or agency's behaviour was fair or whether he/she felt discriminated against. Discrimination surveys may rely on respondents’ self definition of discrimination, rather than whether a legally enforceable right had been breached. (The Mental Health Foundation’s discrimination survey took this approach). Social inclusion, on the other hand, can be measured from either a subjective or objective perspective ie. through finding out whether a person has experienced feeling excluded (subjective) or through measuring actual rates of participation or access to services (objective).
Measuring Social Inclusion

Is social inclusion worth measuring for people with mental health problems?

This section sets out the arguments for and against measuring and reporting on social inclusion for people with mental health problems.

Benefits

To date, there is no comprehensive collection and reporting of data that can present a clear picture of the nature and extent of the social experience of people with mental health problems in New Zealand.

The information that is available is collected by a number of agencies, for varying purposes and often, under broad categories that cannot be disaggregated for mental health purposes. Reporting on social inclusion for people with mental health problems would require pulling together data from a number of existing sources, as well as possibly expanding current surveys by inserting new sets of indicators.

A report could include quantitative data as well as stories and examples of best practice (qualitative). While quantitative data will not provide detail about the nature of the barriers faced by people with mental health problems, it is likely to draw attention to outcomes that differ substantially from the general population. Identified areas can then be followed by further qualitative research into specialised areas, for example, employment issues. In addition, quantitative data tracked over time is likely to become more useful as it starts to show trends.

Some of the potential benefits of measuring and reporting on social inclusion to the mental health sector and other sectors, include:

- providing information that would increase an understanding around barriers to participation for people with mental health problems (especially in contrast to the general population)
- broadening an understanding of discrimination from one that focuses on another person’s behaviour to phenomena that is embedded within systems
- highlighting the importance of upholding rights as a part of promoting inclusion
- bringing greater policy coherence and focus on mental health issues
- highlighting the multiple disadvantages faced by those excluded and the process that has led to social exclusion, and to facilitate the development and implementation of tailored policy approaches
- helping individuals and agencies outside the mental health sector understand how they can play a part in a person’s recovery
- underscoring the importance of having joined-up services (necessary to respond to the individuals’ needs and the interlocking nature of the problems they face)

Phoenix Research’s 2009 report sets out the current data sets that are available that may be relevant to presenting a picture of social inclusion for people with mental health problems.
• identifying the role that social institutions play in systematically excluding people with mental health problems and offering the potential for structural changes that redress this
• providing a platform for further qualitative or quantitative work in the area of promoting social inclusion.

Risks and limitations
There may also be a number of potential risks and limitations of measuring and reporting on social inclusion which include:
• a social inclusion approach may stigmatise people with mental health problems as being socially excluded
• as social inclusion is a normatively defined concept, it may not be useful to use for people who choose not to conform
• a social inclusion approach could detract from the main cause of exclusion which is discrimination
• some of the indicators will need to make use of data from existing collections which will limit the usefulness of the data as it will not be designed for the specific purpose
• indicators (especially those that make use of data from existing collections) may have to be so high-level that they become meaningless and do not reflect the issues that are real for people with mental health problems
• requesting and working with existing data is expensive and time-consuming, as is creating new data via developing new surveys or influencing existing surveys
• populating a comprehensive measurement framework will take many years.

How can we measure social inclusion?
Developing a measuring framework
Assuming it is useful to measure social inclusion for people with mental health problems a proposed framework (the Framework), which aims to be self-explanatory, is set out in Appendix One. This section discusses some of the issues that have informed the development of the Framework.

Life domains
Social inclusion can be measured within life domains. In developing a measuring framework, it is important to identify the dimensions of life that are most indicative of inclusion for people with mental health problems and that are able to tell the story of exclusion and inclusion over time.

The literature suggests that people with mental health problems want inclusion in the situations that most people take for granted and want to be welcomed and valued. The Framework draws from a study undertaken in the United Kingdom that aimed to develop a social inclusion index for mental health (Huxley et al 2006). Their research included conducting concept mapping exercises
with differently composed groups, including mental health service users, professionals and members of the general population. It is interesting to note the ranking of importance of items that emerged from the groups:

<table>
<thead>
<tr>
<th>Ranking of Importance</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First</strong></td>
<td>• Social network and support eg. Friends and family</td>
</tr>
</tbody>
</table>
| **Second**            | • Opportunities  
• Neighbourhood and built environment eg. ghettos, deprivation, surroundings  
• Financial stability  
• Employment  
• Disadvantaged and excluded groups  
• Acceptance including being part of society |
| **Third**             | • Discrimination including stigma  
• Representation: being visible and listened to; having a say  
• Participation  
• Language  
• Housing and life chances  
• Health and well being  
• Engaging in community  
• Diversity, difference, integration  
• Decreased exclusion/opposite of exclusion/including people who have been excluded  
• Choice/freedom/control/power/responsibility  
• Access  
• Service provision |
| **Fourth**            | • Confidence/sense of purpose/fulfilment/achievement  
• Isolation  
• Having a meaningful, recognised and valued role  
• Barriers to inclusion  
• Understanding  
• People's behaviour  
• Transport and mobility  
• Safety, fear, crime, conflict  
• Respect  
• Religion (ignorance and tolerance)  
• Education |
These themes can be reduced down to a number of life domains:

- family activity
- social networks
- employment
- income & financial services
- community participation/leisure
- housing
- transport
- mental health
- physical health
- education & training
- civil/justice.

**Developing indicators that are relevant**

One of the greatest challenges in developing indicators is making the indicators meaningful to service users and their families while also meeting the needs of service providers and policy makers.

It is important to consider why we are measuring social inclusion and the use to which any indicator is to be put in order to ensure its relevance to mental health, cultural groups, different genders and age groups. There are many different reasons to measure social inclusion and it may not be possible to use a social inclusion measure that has not been designed with that particular purpose in mind (Huxley et al 2006: 47).

Some possible purposes and sought effects of a model to measure social inclusion include (Huxley et al 2006: 48):

- to measure the impact or influence of a policy
- assist the development of a theory
- assess the outcome of certain practices
- assess the efficacy of research in a particular area
- evaluate the effectiveness of a programme
- to measure the impact at a real life/personal level.

The Framework is designed to provide a broad foundation for measuring the extent to which people with mental health problems are socially included. It can potentially be used as a starting point for any of the above purposes although it has been primarily designed to monitor changes in a population over time. The Framework is not designed to capture functioning at an individual level or the effectiveness of clinical services.
The indicators included in the Framework are presented at a first level and focus on a person’s opportunity to participate in key activities, access resources or exercise particular rights. Further work will need to be completed to develop the indicators so that they fit the particular purpose for which they are being used and to ensure they become meaningful.

Application of the Framework will provide information that shows the levels of exclusion. These results will be indicative of the levels of indirect discrimination that exist in each life domain. However, the Framework does not pinpoint the cause of exclusion and it needs to be kept in mind that discrimination is only one possible cause. There may also be other causes of exclusion as discussed previously in this paper.

The Framework does not capture information about direct discrimination as other models already exist for capturing this type of information.

**Objective and subjective indicators**

Social inclusion can be measured subjectively and objectively. A distinction has been made between the individual sense of inclusion and governments’ definitions of it (Bates 2005).

In using social inclusion as a concept, it needs to be recognised that it is normatively defined. This is potentially a major limitation of objective indicators. For example, citizenship is often thought of as having a job, home or financial security according to the norms of society. However, some individuals choose to exclude themselves from these key areas of life that the majority consider indispensable or they may value certain activities more than other people.

The question of self-exclusion is not straightforward though, in that some commentators have pointed out that while information about an individual’s preferences is important in any evaluation, an individual’s subjective state may need to be treated with caution. This is especially where low self-esteem, experience of discrimination and long-term deprivation are prevalent (Burchardt 2005). In these situations an individual’s expectations may be so reduced that a subjective assessment may only tell part of the story.

The benefits of objective (social) indicators are that they are independently verifiable and can provide policy makers with useful data. However, they may also appear remote and irrelevant to many groups including service users and providers. This is especially the case where social indicators are aggregated at area level for policy and planning purposes. For example, a policy maker may find it useful to know the number of people in employment with mental health problems as an indicator of social inclusion, whereas for an individual service user this particular indicator may not be important. Social inclusion to that individual may mean being able to work on a voluntary basis. To another individual it may mean being able to access a leadership position.

The quality of each inclusion domain is also important in that social inclusion is not merely about accessing a specific resource. The resource has to be of a certain quality and respond adequately to the needs of the individual in order for inclusion to occur.

The Framework attempts to take into account different needs and provide the opportunity for different perspectives to be shown. The Framework focuses on the availability of opportunity that a person has to participate, access resources or exercise his/her rights. It focuses on the availability of opportunity from a subjective (individual) perspective as well as from an objective (social) perspective.
The Framework also measures individuals’ perceptions of the inclusion opportunity: whether they consider the opportunity to be of value; the extent to which they consider they have access to the opportunity; the perceived adequacy of the opportunity; and whether they want the situation to change.

The real life impacts and implications of exclusion are perhaps best served by the subjective (individual) measures and the purposes of policy by the objective (social) indicators, although a mixture of both approaches may prove most beneficial in bringing together a ‘holistic’ picture of social inclusion. Not every indicator will be relevant to everyone, but every indicator must fit within a broad understanding of social inclusion.

**Availability of data**

The Phoenix Research report (2009) provides detail on the data sets currently available and makes recommendations as to how further data could be collected.

There are limitations to how much data can be collected and reported on. For this reason, the indicators need to be prioritised based on their usefulness and the practicalities of obtaining the data. Service users should be actively involved in developing the indicators further.
Appendix One
Framework for Measuring Social Inclusion

The following sets out a framework that could be used for measuring social inclusion for people who experience mental health problems.

This framework has been adapted from a number of sources including the Social Inclusion Index developed for the UK National Coordinating Committee for Research Methodology (Huxley 2006).

What this framework is for
This framework is focused on adults of working age with mental health problems.

It sets out some suggested indicators for inclusion as a resource to researchers, policymakers, monitoring agencies and service providers looking to collect data and advance inclusion for people who experience mental health problems.

This tool is primarily designed to monitor changes in a population over time. The framework is not designed to capture functioning at an individual level or the effectiveness of clinical services.

Definition
Social inclusion is the extent to which people are able to exercise their rights and participate, by choice, in the ordinary activities of citizens in the society in which they reside.

Social inclusion can be a subjective experience or an objective state.

How to use this framework
The framework is divided into categories to reflect the different life domains that make up the ordinary activities of citizens. All the indicators relate to the experience of inclusion for individual service users (as opposed to reflecting whether or not mental health services practices are socially inclusive).

The framework sets out first level indicators for each of the domains. The indicators are not intended to be definitive or prescriptive. These were selected as being those thought to be most suited to evidencing progress in each category. Further work will need to be completed to develop the indicators to fit the particular purpose for which they are being used.

The framework focuses on the availability of opportunity that a person has to participate, access resources or exercise his/her rights. It focuses on the availability of opportunity from the individual’s perspective as well as from an objective (social) perspective. The framework also captures the person’s subjective perception of the value or benefit of the activities in each life domain and whether he/she wishes to have more or less or the same level or type of participation or ability to exercise his/her rights.
Application of the framework will provide information that shows the levels of exclusion. These results will be indicative of the levels of indirect discrimination that exist in each life domain. However, the framework does not pinpoint the cause of exclusion and it needs to be kept in mind that discrimination is only one possible cause. There may also be other causes of exclusion.

This framework does not capture information about direct discrimination as other models already exist for capturing this type of information.

**Approaches to measurement**

Some of the approaches to data collection that may be used to populate the framework are:

- questionnaires
- interviews
- observation by different parts of the sector
- administrative data
- case note review.

People who might contribute to making an assessment regarding outcomes include:

- service users (self-assessment)
- carers and significant others
- mental health workers
- data collecting agencies.
### Social inclusion indicators

#### Domain | Subjective/individual | Objective/societal
---|---|---
**Opportunity to participate/access resources/exercise rights**

- Extent to which person values the opportunity to participate/access resources/exercise rights
- Extent to which person perceives he/she can participate or access resources/exercise rights
- Extent to which the individual wants the situation to change
- Actual rates of participation/access to resources/exercising of rights

#### Family activity

- People with mental health problems participate in family activities (where family exists)

<table>
<thead>
<tr>
<th>Family activity</th>
<th>Level of benefit/value</th>
<th>Perceived adequacy</th>
<th>More/less</th>
<th>Same/different</th>
<th>Level of contact</th>
</tr>
</thead>
</table>

#### Social networks

- Opportunity exists to participate in a range of social networks
- Opportunity exists to participate in social and caring roles

<table>
<thead>
<tr>
<th>Social networks</th>
<th>Level of benefit/value</th>
<th>Perceived adequacy</th>
<th>More/less</th>
<th>Same/different</th>
<th>Level of social contact</th>
</tr>
</thead>
</table>

#### Employment

- Opportunity to prepare for employment by building work capacity and skills for looking for work
- Opportunity to enter paid employment
- Opportunity to receive support to retain employment

<table>
<thead>
<tr>
<th>Employment</th>
<th>Level of benefit/value</th>
<th>Perceived availability</th>
<th>More/less</th>
<th>Same/different</th>
<th>Use of services</th>
<th>Employment rate % in labour force</th>
</tr>
</thead>
</table>

#### Income & financial services

- Has adequate income
- Receives appropriate benefits and/or financial advice
- Opportunity to control own support (hold own budget)

<table>
<thead>
<tr>
<th>Income &amp; financial services</th>
<th>Level of benefit/value</th>
<th>Perceived adequacy</th>
<th>More/less</th>
<th>Same/different</th>
<th>Level of income</th>
<th>Actual use of services</th>
</tr>
</thead>
</table>

#### Community participation/leisure

- Community facilities exist and participation in local community activities possible
- Opportunity to volunteer in mainstream settings
- Access to leisure activities
- Opportunity to participate in regular exercise

<table>
<thead>
<tr>
<th>Community participation/leisure</th>
<th>Level of benefit/value</th>
<th>Perceived adequacy</th>
<th>More/less</th>
<th>Same/different</th>
<th>Use of facilities</th>
<th>Level of participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>Opportunity to participate/access resources/exercise rights</td>
<td>Subjective/individual</td>
<td>Objective/societal</td>
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<td></td>
<td>Extent to which person values the opportunity to participate/access resources/exercise rights</td>
<td>Extent to which person perceives he/she can participate or access resources/exercise rights</td>
<td>Extent to which the individual wants the situation to change</td>
<td>Actual rates of participation/access to resources/exercising of rights</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td>• Access to adequate housing</td>
<td>Level of benefit/value</td>
<td>Perceived adequacy</td>
<td>More/less</td>
<td>Same/different</td>
<td>Actual quality level of independence</td>
</tr>
<tr>
<td></td>
<td>• Opportunity to live in independent accommodation</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Access to safe neighbourhood</td>
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<td></td>
<td></td>
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<tr>
<td>Transport</td>
<td>• Access to public transport</td>
<td>Level of benefit/value</td>
<td>Perceived availability</td>
<td>More/less</td>
<td>Same/different</td>
<td>Actual use</td>
</tr>
<tr>
<td></td>
<td>• Access to private transport</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mental health</td>
<td>• Access to mental healthcare at primary care level</td>
<td>Level of benefit/value</td>
<td>Perceived availability</td>
<td>Perceived adequacy</td>
<td>More/less</td>
<td>Same/different</td>
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<tr>
<td></td>
<td>• Access to mental healthcare at specialist care level</td>
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<tr>
<td></td>
<td>• Access to services which specifically meet the needs of under-represented groups eg. Maori</td>
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<td></td>
<td>• Opportunity to be involved in the design, delivery, management, review and development of individual recovery/care plan</td>
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<tr>
<td></td>
<td>• Opportunity to be involved in the design, delivery, management, review and development of mental health services</td>
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<tr>
<td></td>
<td>• Opportunity to deliver mental health services and/or activities</td>
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<tr>
<td>Physical health</td>
<td>• Access to medical treatment for physical conditions</td>
<td>Level of benefit/value</td>
<td>Perceived availability</td>
<td>Perceived adequacy</td>
<td>More/less</td>
<td>Same/different</td>
</tr>
<tr>
<td>Education &amp; training</td>
<td>• Access to education and training opportunities</td>
<td>Level of benefit/value</td>
<td>Perceived availability</td>
<td>More/less</td>
<td>Same/different</td>
<td>Actual use level of attainment</td>
</tr>
<tr>
<td>Civil/justice</td>
<td>• Opportunity to access complaints/review mechanisms</td>
<td>Level of benefit/value</td>
<td>Perceived availability</td>
<td>Perceived adequacy</td>
<td>More/less</td>
<td>Same/different</td>
</tr>
</tbody>
</table>
References


*Social Inclusion Principles: Origins, concepts and key themes.* 2008. Paper presented by the Australian Institute of Family Studies to the Social Inclusion Unit, Department of the Prime Minister and Cabinet.

