



Psychiatric Disability Services of Victoria (VICSERV)





VICSERV Pathways to Social Inclusion

Social Inclusion: an outcome measure for the mental health service system

Facing the facts

- 85.2% of people living with severe mental illness are recipients of a government pension
- Their death rate is 2.5 times greater than that of the general population
- The unemployment figure for this group is 19.5%
- Carers, on average, contribute over 100 hours per week caring for those with mental illness.

Better outcomes are possible

- Evidence shows that social inclusion is intrinsically linked to recovery
- Paid work is associated with reduced psychiatric symptoms and higher functioning
- Increased participation in meaningful vocational activities by just 10.0% of unemployed people with psychosis could potentially save society around \$147 million per annum
- It is time for a new agenda that fundamentally shifts and shares effort to building socially inclusive communities.

Our call for action

- Invest substantially in the PDRSS sector
- Use and add to the evidence of good practice
- Create effective links at policy, planning and implementation levels
- Develop a benchmarking framework that provides for comparison of agreed outcome measures relating to health, housing, employment and education.

Twenty-five years on... the unfinished business of de-institutionalisation

During the 25 years since de-institutionalisation there have been three national mental health plans and a national inquiry into the human rights of people with mental illness. Despite this effort and the intention that drove de-institutionalisation, the health and life outcomes for people living with serious mental illness are, overall, very poor. People living with severe mental illness are homeless (and imprisoned) more often than others, their health status is poor, they are more likely to be unemployed, and their engagement with education and connections to the community are often tenuous.

- The unemployment figure for this group is 19.5% (compared to 4.2% for the overall population.)
- 47.8% have not finished secondary school or achieved post-secondary qualifications and 85.2% are recipients of a government pension.
- 42.0% live in unstable forms of housing (i.e. institutional settings, hostels, boarding houses, rented rooms, crisis accommodation, shelters) or are amongst the primary homeless.
- Their overall health status is far lower than the mainstream population resulting in significant health inequalities. The death rate of people with mental illness is 2.5 times greater than that of the general population, which is equivalent to a life expectancy of 50 to 59. People with schizophrenia have a mortality rate that is up to three times higher than that of the general population.
- The 12-month prevalence rate of psychosis in the prison population is 9.0%, which is 30 times higher than the non-prison population.
- There is ongoing stigma and discrimination against people with severe mental illness.
- Carers, on average, contribute in excess of 100 hours per week caring for those with mental illness. They too, are at risk of poor health outcomes.

Clearly, current policy and service responses are inadequate for people with severe mental illness, their carers and families. Individuals, service systems (including mental health) and communities are yet to respond to de-institutionalisation in ways that truly work to support recovery and the fulfilment of core human rights. The solution will not be found in 'more of the same'. It is time for a new agenda that fundamentally shifts and shares effort to building socially inclusive communities in which people living with serious mental illness are effectively supported to engage and participate in society.

A growing commitment to social inclusion

In July 2008, Australia became one of the first nations to ratify the *United Nations Convention on the Rights of Persons with Disabilities*. Signatories to the Convention agree to promote communities in which all people with disabilities are included as equal and active citizens. There is currently also considerable interest in the notion of social inclusion across government jurisdictions – in particular, the creation of a new Social Inclusion Board and Minister for Social Inclusion at the federal level.

In order to complete the tasks associated with de-institutionalisation and achieve better outcomes for people living with severe mental illness, mental health reform (approaches and systems) must be clearly linked to achieve authentic social inclusion. It is critical that the mental health change agenda does not take a narrow, 'siloed' approach that over-emphasises clinical responses and fails to tackle seriously the broader socio-economic determinants and risk factors that contribute to relapse, which prevent recovery.

Because Mental Health Matters

In Victoria, there is a review and reform process underway for the mental health service system. This ministerially initiated process includes the release of a consultation paper, *Because Mental Health Matters*. The paper identifies several issues associated with the operation/impact of the current system, including the lack of respect, dignity, involvement and control given to consumers in some parts of the sector. The paper also acknowledges a growing concern for the poor treatment of people with mental illness in other spheres of life including housing, employment, education, and day-to-day aspects of community and neighbourhood living.

Whilst the paper recognises the importance of providing psychosocial supports to improve daily living skills and address health and welfare issues that can impact on continued recovery (e.g. housing needs and connection to family and community), there remains a serious risk that the new policy direction will simply see 'more of the same':

- Continued dominance of the clinical/medical model in terms of authority, investment and focus of reform.
- Continued neglect of the physical wellbeing of people living with a severe mental illness.
- Failure to take the necessary steps to broaden the agenda and ensure improved mental health outcomes through social inclusion strategies – including (but not limited to) community development and capacity building efforts to address the causes and 'symptoms' of stigma.
- Limited recognition and understanding of the role of carers as partners in the service system and their needs during the course of their life stages.

- Limited responses to cultural diversity i.e. modification of dominant paradigms rather than deep reform that works in harmony with cultural understandings of illness and health.
- Limited concepts of integration i.e. substantial focus on the relationship between clinical mental health services and Psychiatric Disability Rehabilitation and Support Services (PDRSS).
- Failure to achieve the level of upfront investment and associated reform required to provide housing, employment, education and other supports known to make a positive difference to recovery and overall outcomes.

Mental health reform in Victoria (and elsewhere) must be clearly underpinned by a social inclusion agenda that leads and links across other departments/sectors including health, housing, education, employment and community strengthening. This social inclusion response must be fully integrated into clinical and support services. The whole person (not the mental illness) and whole communities must be at the centre of this response.

Social inclusion, recovery and the business base

A social inclusion approach to mental illness makes good policy sense. Social inclusion is intrinsically linked to recovery, often described as a 'journey' towards greater participation and citizenship. Evidence shows:

- A sense of belonging to community makes people feel cared for, loved and valued, which in turn protects wellbeing. On the flipside, exclusion is linked to unhappiness, illness and reduced life expectancy. There is a strong correlation between poor social networks and mortality from almost every cause of death.
- There is better recovery after disease when opportunities for social interactions are in place.
- Social inclusion is linked with relapse prevention for people with severe mental illness.
- Low social supports increase the risk of onset and decrease the chance of recovery.
- Paid work is associated with reduced psychiatric symptoms, higher functioning, improved sense of self worth, and significant improvement in social skills.

Currently, the cost of treatment is extremely high, with bed-based hospital care the main driver/contributor. This investment is not achieving desired outcomes. Evidence indicates that considerable cost benefits are to be attached to increase community-based supports that address 'whole of life' needs. For example:

- Increased participation in meaningful vocational activities by just 10.0% of unemployed people with psychosis, could potentially save society around \$147 million per annum in costs. If the rate of participation increased by 30.0%, the savings would be in the order of \$441 million per annum.
- The estimated average recurrent cost of providing one mental health hospital bed is around \$150,000 per year compared to one unit of public housing at \$5,990 per year.

A balanced approach: a broader focus for mental health services in Victoria

Whilst respecting the importance of clinical treatment to stabilise symptoms, it is time to redress the imbalance that sees disproportionate investment in this aspect of acute and continuing care. It is time to develop a mental health policy/system that demonstrates an understanding of a 'whole of person', 'whole of life', consumer and community-centred response and its role in improved outcomes—and how this response can optimise continued investment in clinical services as well.

It is time to create an integrated and forward-thinking response that will:

- Address, in equal measure, the social and clinical risk (and protective) factors that impact on people living with severe mental illness.
- Formulate specific policy and strategy in the areas of primary health (and chronic illness), housing, education, employment and community strengthening that respond to the needs of people with severe mental illness.
- Invest substantially in the PDRSS sector and the development of flexible services/funding models that allow for:
 - Scalable responses
 - Linkage with clinical mental health services and other sectors (e.g. health, housing, employment and education)
 - Targeted, non-emergency after-hours support
 - Consistent and adequately-resourced approaches for working with carers and families.
- Reliably forecast need to enable considered, proactive and integrated responses.
- Use and add to the evidence of good practice (including working with diverse communities).
- Invest in addressing stigma and changing attitudes.

- Assure adequate long-term investment in stable and appropriate housing options.
- Create effective links at policy, planning and implementation levels. Better linkage and synergy must be achieved across government jurisdictions (federal and state) as well as with an extended range of policy makers and funding bodies, who have the capacity to be part of the solution.

The VICSERV propositions: social inclusion, innovation and better outcomes

A commitment to human rights and good practice evidence combine to underscore the importance of social inclusion as a driver for mental health reform and a shared framework for measuring and monitoring outcomes.

Overarching VICSERV approach

In order to emphasise the need for this approach VICSERV has developed four propositional papers. The current paper, *Social Inclusion: an outcome measure for the mental health service system*, is the first in the series, serving as a conceptual introduction to the others:

- *Health Inequalities: policy and practice failure*
- *Housing and Support: a platform for recovery*
- *Economic Participation: employment and education – changing outcomes*

Each paper summarises the relevant evidence for change including current outcomes, systemic weakness and barriers, and good practice evidence. Importantly, each paper proposes a set of action, linkage and investment priorities. Together, the papers constitute the **VICSERV Pathways to Social Inclusion**. They are intended to add to the discussion on their respective issues and provide shared and concrete ways forward.

Papers can be accessed at www.vicserv.org.au or telephone (03) 9519 7000.

Additional proposition – benchmarking

Whist the propositions contained in the papers build towards achieving markedly improved levels of social inclusion—and as a consequence, better mental health outcomes—it is also necessary to develop change goals and benchmark achievement to fully embed social inclusion as a jointly-owned outcome.

VICSERV proposes the development of a benchmarking framework that provides for comparison of agreed outcome measures (at agreed intervals in time) related to health, housing, employment and education:

- between Australia and other OECD countries,
- between Victoria and other states and territories within Australia,
- with current outcomes in the relevant sectors, and
- with current ways of working in clinical and PDRSS sectors.

Investment required

There is an initial piece of work to be undertaken to determine a set of (broad and higher level) measures and engage key stakeholders. It is proposed that this work be initiated through the new Social Inclusion Board and is supported by mental health reform leaders in Victoria and representatives from other (state and national) bodies. The level of investment requires further consideration, although it is expected the cost will not be particularly high.

In a parallel process, VICSERV, through its members, intends to develop its own 'scorecard' approach in relation to ways of working and outcomes that reflect a social inclusion agenda.

Looking forward

The *VICSERV Pathways to Social Inclusion* is a dynamic and ongoing piece of work that VICSERV intends to update and add to over time. Upcoming priority areas for investigation and a propositional approach include:

- (a) *Diversity – different needs, different approaches, different outcomes.* This work will consider in depth, outcomes, barriers and approaches using gender, indigeneity, cultural diversity, and sexual orientation as lenses for analysis.
- (b) *Carers and Families – hidden partners.* This work will consider in depth, the contributions and roles of carers, the different cohorts of carers, and the needs of carers at stages of their lives and in the recovery journey of care recipients.
- (c) *Justice, Injustice and People Living with Mental Illness.* This work will consider the experiences and needs of people living with a severe mental illness in the criminal justice system, as well as systemic requirements necessary to enable improved responses to illness symptomatology and support needs.

VICSERV is interested in and willing to undertake developmental work in partnership with governments and/or key sector stakeholders to progress these ways forward.

Social Inclusion: an outcome measure for the mental health service system

Background paper

Recent directions and initiatives

United Nations Convention on the Rights of Persons with Disabilities

In July 2008, Australia became one of the first nations to ratify the *United Nations Convention on the Rights of Persons with Disabilities*. The Convention recognises that if the rights and freedoms of individuals enshrined in the *Universal Declaration of Human Rights* are to be truly universal, then they must be inclusive of people with disabilities—including those with psychiatric disability. Signatories to the Convention agree to promote communities in which all people with disabilities are included as equal and active citizens.¹

Federal Social Inclusion Board

This recently created cabinet-level committee provides expert advice to the Minister for Social Inclusion and the Prime Minister to help progress a social inclusion agenda. The agenda hopes to increase opportunities for participation amongst those who are most marginalised and excluded from mainstream society. Early priorities include responding to the employment needs of people with disabilities (including those living with severe mental illness) and addressing the incidence of homelessness. It is also hoped that the social inclusion agenda will usher a 'new era of governance' that will see governments at all levels—federal, state/territory and local—working together and across different departments to shape policies and deliver services necessary for greater inclusivity.²

South Australian Social Inclusion Unit

Since 2002, the South Australian Government has had a Social Inclusion Unit to address a range of social issues stemming from exclusion, such as homelessness and problematic drug use. The Unit is accountable directly to the Premier. Its agenda encompasses initiatives and priorities that sit in several departments but are unified through a single vision of an inclusive society. In 2005, the Unit was given the responsibility of reforming the state's mental health service system in recognition that people living with mental illness often experience the most extreme forms of exclusion.³

Victorian initiatives

(a) *Because Mental Health Matters: A New Focus for Mental Health and Wellbeing in Victoria*. This consultation paper, produced for the review/reform of Victoria's mental health service system, identifies a number of issues since de-institutionalisation, such as the lack of respect, dignity, involvement and control given to consumers in some parts of

¹ More on Australia's signing of the Convention can be found at: http://www.hreoc.gov.au/disability_rights/convention.htm.

² More on the social inclusion agenda and Board can be found at: <http://www.socialinclusion.gov.au/>.

³ State Government of South Australia (2006) *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007 – 2012*, Adelaide: South Australian Government Social Inclusion Board.

the sector.⁴ Importantly, the paper acknowledges a growing concern for the poor treatment of people with mental illness in other spheres of life including housing, employment, education, and a myriad of day-to-day aspects of community and neighbourhood living.

In recognition of the link between these spheres of life and mental health outcomes, the paper makes a claim for mental health service reform together with a strengthening of social inclusion efforts for people living with mental illness – here building on the Victorian Government’s key social policy platform to address discrimination, marginalisation, exclusion and inequalities as outlined in *A Fairer Victoria*.⁵ Service reform, in parallel with social inclusion initiatives, would see stronger linkages between different parts of the mental health service system (e.g. clinicians and the PDRSS sector) as well as across different government departments and service sectors:

*When the person is acutely unwell, the role of the clinician should be emphasised. As the person’s symptoms stabilise, that emphasis should shift to the provision of psychosocial supports (including PDRSS), with a focus on improving the person’s daily living skills and addressing any broader health and welfare issues that may be impacting on their recovery, such as housing, connection to family and culture, and meaningful activities that promote social inclusion.*⁶

(b) *Charter of Human Rights and Responsibilities*. The Charter enshrines the intrinsic value of an inclusive society free from discrimination, and there are now obligations on all public authorities to comply with a rights-based agenda to social inequalities: a first for any Australian jurisdiction. Victoria also expects to review the *Victorian Mental Health Act 1986* during the next two years to ensure it provides an effective legislative framework for mental health services in light of the Charter.

(c) *Victorian Health Promotion Foundation (VicHealth) Research and Activity*. VicHealth has extensively explored social inclusion as a key determinant of mental health and wellbeing.⁷ Social inclusion is a named program area within the VicHealth agenda, and the organisation currently collaborates with a range of partners across sectors to promote inclusive societies as a counter to discrimination, marginalisation and exclusion.

Three meanings: which one?

There are at least three meanings that can be attributed to the term, social inclusion.⁸ The originating meaning—used by the Blair Government in the UK—sees social inclusion as the solution to marginalisation, disadvantage and inequality in society. This meaning places social inclusion within a human rights and equity agenda; and sees an explicit role for governments

⁴ State Government of Victoria (2008) *Because Mental Health Matters: A New Focus for Mental Health and Wellbeing in Victoria*, Consultation Paper, Melbourne: Victorian Government Department of Human Services.

⁵ State Government of Victoria (2008) *A Fairer Victoria: Achievements So Far*, Melbourne: Victorian Government Department of Premier and Cabinet.

⁶ State Government of Victoria, (2008) *Because Mental Health Matters*, op. cit. p.

⁷ Victorian Health Promotion Foundation *Mental Health Action Plan* available at: www.vichealth.vic.gov.au.

⁸ Scanlon C (2008) ‘Lessons for Rudd as social inclusion moves to top of agenda’ in *newparadigm*, Autumn, pp. 10-11.

to put into place actions that will remove barriers and foster participation by all citizens in the social, economic, institutional and symbolic fabric of life.

The second meaning of social inclusion regards it as an individual responsibility, with those left out due to their own failings. The third meaning defines social inclusion as social integration or cohesion (i.e. communities getting along). The second meaning is devoid of the focus on inequalities that comes with the first meaning; and whilst the third meaning has a lovely aspirational sound, it can drift into something like the second meaning – this time by leaving it up to individuals in communities to cohere simply by being nicer to each other. Integration/cohesion is good; the trick is to keep the aspiration close to the social justice goal of a fairer society.

The meaning of social inclusion that best serves people with severe mental illness is the original one, with the understanding that the third definition also has a place as long as it doesn't stray from a social justice platform. This is because the lives of people with severe mental illness are characterised by a significant compounding of disadvantage that creates exclusion on a number of fronts; and unless we address these facets of exclusion through coherent policy and an integrated service system response, this group will never experience true social inclusion.

The five facets of exclusion: ⁹

1. *Relational Exclusion*: refers to poor social ties or connectedness. Sites of relational exclusion include the family, neighbourhood, workplace/vocational setting, and wider community.
2. *Economic Exclusion*: refers to lack of resources (wages and income support) and the capacity to consume goods and services.
3. *Institutional Exclusion*: the result of inequitable access to a range of institutions such as justice, education, health and welfare.
4. *Geographic Exclusion*: refers to spatial clustering of people in specific locations or neighbourhoods. Disadvantaged groups, for example, can be housed in specific areas, institutionalised, detained or incarcerated.
5. *Symbolic Exclusion*: refers to poor/low sense of belonging, purpose, agency, identity, future and hope.

Evidence of exclusion

After 25 years of de-institutionalisation, three national mental health plans, and a national inquiry into the rights of people with mental illness, people with serious mental illness experience levels of exclusion that suggest 'institutionalisation' in a different form.¹⁰ As noted by the Mental Health Coordinating Council (MHCC), when discharged into the community 'consumers can find themselves in conditions comparable to those in institutions, either literally

⁹ These facets are drawn (and slightly modified) from Robinson, C (2003) *Understanding Iterative Homelessness: The Case for People with Mental Disorders*, Melbourne: Australian Housing and Urban Research Institute, p. 13.

¹⁰ More on the most recent Council of Australian Governments' *National Action Plan on Mental Health (2006-2011)* can be found at <http://www.health.gov.au/coagmentalhealth>. The *Report of the National Inquiry into the Human Rights of People with Mental Illness* (1993) – also known as the Burdekin report – can be found at http://www.hreoc.gov.au/human_rights/mental_illness/index.html.

(in prison or sub-standard housing) or figuratively – including isolation, discrimination and hopelessness for the future.¹¹ Statistics show that the business of de-institutionalisation is far from finished. People with severe mental illness:

- Are unemployed (economic exclusion): The most recent unemployment figure for this group puts it at 19.5%, compared to 4.2% for the overall population.¹²
- Have low levels of educational attainment (institutional exclusion): 47.8% have not finished their secondary school education or achieved post-secondary qualifications.¹³
- Are dependent on welfare support (economic exclusion): 85.2% receive a government pension or social benefit (in particular, the disability pension) as their main income source.¹⁴
- Experience iterations of homelessness (geographic exclusion): 19.6% are in institutional settings, 13.6% live in hostels, and 8.8% live in other marginal housing (e.g. boarding houses, rented rooms, crisis accommodation, shelters) or are amongst the primary homeless.¹⁵
- Experience barriers to mainstream health services (institutional exclusion): A fragmented and disjointed health service system means that people's physical health needs are commonly overlooked either until a medical emergency occurs, or it is too late. People living with severe mental illness have an overall health status that is far lower than the mainstream population resulting in significant health inequalities. The death rate of people with mental illness is 2.5 times greater than that of the general population, which is equivalent to a life expectancy of 50 to 59. People with schizophrenia have a mortality rate that is up to three times higher than that of the general population.¹⁶
- Have difficulties building and maintaining social ties (relational exclusion): 31.3% live alone in single-person households and only 9.3% have a person at home they can describe as a carer (most often a mother or partner). Around 84.1% are single, divorced, separated or widowed. Some 47.1% report not sharing meals with others; 40.0% do not watch television with others; and 39.8% do not do chores or run errands with others. In terms of friendships, 39.1% report having no 'best friend' with whom they can share thoughts and feelings and 44.9% feel they need 'good friends' in their lives.¹⁷

¹¹ Merton R and Bateman J (2007) *Social Inclusion: The Importance to Mental Health*, Roselle, NSW: Mental Health Coordinating Council, p. 19.

¹² See *Economic Participation: Employment and Education – Changing Outcomes. Background Paper* for details.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ See *Housing and Support – A Platform for Recovery. Background Paper* for details.

¹⁶ See *Health Inequalities – Policy and Practice Failure. Background Paper* for details.

¹⁷ Jablensky A, McGrath J, Herrman H, Castle D, Gureje O, Morgan V and Korten A (1999) *People Living with Psychotic Illness: An Australian Study 1997-98*, National Survey of Mental Health and Wellbeing Report 4, Canberra: Mental Health Branch, Commonwealth Department of Health and Ageing. This study was part of the first National Survey of Mental Health and Wellbeing. The second National Survey of Mental Health and Wellbeing was conducted in 2007 with preliminary results available in late 2008.

- Are over-represented in the criminal justice system (institutional exclusion): the 12-month prevalence rate of psychosis in the prison population is 9.0%, which is 30 times higher than the non-prison population.¹⁸
- Are stigmatised and feel the effects of discrimination on a daily basis e.g. relational, economic, institutional, geographic and symbolic exclusion. (See below.)
- Have a low sense of belonging, agency and purpose - symbolic exclusion. (See below.)

Stigma – both cause and symptom of exclusion

Stigma means to be marked by others as shameful. To be stigmatised is to be disgraced and disapproved by others—and to a certain extent to internalise their views (to become the ‘disgraced’ etc.) Historically, mental illness has generated misunderstandings, misconceptions, myths and fear in the community. These have made it all too easy for others to stigmatise people with mental health issues and to keep them at the edges of society.

When asked about what things would make the biggest difference in their lives, people affected by severe mental illness say reducing stigma.¹⁹ Indeed, many report that living with stigma is worse than having a mental illness.²⁰ Carr and Halpin note that stigma has a huge bearing on the quality of life of consumers. Drawing on an extensive body of literature, they write:

Sigma promotes and reinforces social isolation, limits equitable opportunities for employment and recreation, discourages treatment-seeking by those who need it, creates, reinforces and sustains pseudo-psychiatric mythology, and is frequently internalised by people with a mental illness resulting in much suffering.²¹

Because stigma is so widespread in the community, the mainstream population is often reluctant to engage with people who have severe mental illness – thereby further perpetuating misconceptions about mental illness. In this sense, stigma leads to a range of relational exclusions from family and neighbourhood/community networks to places of study and employment.

When myths about people with mental illness are circulated in the workplace (e.g. that they are unfit for work) then this can mean employers are reluctant to employ them. In this sense, stigma has a direct bearing on economic exclusion. When fears about people with mental illness exist in the housing sector (e.g. that they are inherently violent, dangerous or untrustworthy) then this can make it hard for consumers to obtain accommodation in their place of choice. This is how stigma relates to geographic exclusion.

¹⁸ See *Housing and Support – A Platform for Recovery. Background Paper* for details.

¹⁹ Research by SANE Australia as cited in Carr V and Halpin S (2002) *Stigma and Discrimination*, National Survey of Mental Health and Wellbeing Bulletin 6, Canberra: Mental Health Branch, Commonwealth Department of Health and Ageing, p. 1.

²⁰ Commonwealth of Australia (2005) ‘Challenging stigma’, Response Ability Project, Australian Government Department of Health and Ageing, available at http://www.responseability.org/client_images/33762.pdf and accessed 31/07/08.

²¹ Carr and Halpin, op. cit., p. 3.

When beliefs about people with severe mental illness are held by institutions such as health, justice, welfare and education (e.g. that they have low aspirations in life or their physical health needs are not important) then this can mean that our very systems fail to support those most in need. This is how stigma relates to institutional exclusion.

All of this can leave consumers feeling shamed, disgraced, humiliated, ostracised, despairing, hopeless, disenfranchised, and in a state of 'not belonging' – or in other words: symbolically excluded.

Social inclusion and recovery

Social inclusion is good for recovery. Recovery is grounded in principles of empowerment and self-determination.²² It refers to the re/gaining of control of one's life by learning to manage mental illness and its impacts. It does not mean cure, since many symptoms of mental illness can remain and there may be relapses and struggles with the illness again. For many, what is recovered is a sense of self and purpose, a way of living with the illness (its ebbs/flows and non-linearity) rather than being defined or controlled by it. In other words, a sense of being that enables a new relationship with self and community. Recovery is often described as a 'journey' towards greater participation and citizenship.

In Victoria, the PDRSS sector plays an important role in the journey of recovery of consumers. PDRSS provide specialist support services to people with significant impairment resulting from severe mental illness using a psychosocial rehabilitation approach to recovery.²³ PDRSS employ community-based psychosocial rehabilitation approaches to enable consumers to 'survive, thrive and build on their strengths' as members within their communities. Such approaches 'emphasise the wholeness and wellness of the individual' (i.e. are strengths-based) and make use of a range of services to develop skills, build confidence, reconnect, and increase opportunities in life. PDRSS recognise that recovery is a complex and lengthy process, and acknowledge the total life impacts of severe mental illness rather than only the illness (symptoms) per se.

The link between social inclusion and mental health and wellbeing in a general sense is well documented. According to VicHealth:²⁴

- Social networks (defined as ties, connectedness, integration, activity and embeddedness) provide emotional support, companionship and opportunities for engagement in many areas of life. By providing connections and links, social networks also act as a buffer during times of stress.

²² For this discussion, see Crosse C and Hocking B (2004) *Social Rehabilitation: What are the Issues?* Paper for the DVA National Rehabilitation Conference, Melbourne: SANE Australia. See also Merton and Bateman, op. cit., pp. 5-6.

²³ Clark D (2003) *The Development of Psychiatric Disability Rehabilitation and Support Services in Victoria*, Elsternwick, VIC: VICSERV.

²⁴ Victorian Health Promotion Foundation (2005) 'Social inclusion as a determinant of mental health and wellbeing', Melbourne: Victorian Health Promotion Foundation.

- A sense of belonging to the community makes people feel cared for, loved and valued, which in turn protects wellbeing. On the flipside, exclusion is linked to unhappiness, illness and reduced life expectancy. For example, people with few social networks are more likely to have poor health and to be at risk of (or indeed experience) some level of psychological distress. There is a strong correlation between poor social networks and mortality from almost every cause of death.
- Positive supportive relationships can foster healthier behaviour patterns and protect against less risky health behaviours.
- There is better recovery after disease when opportunities for social interactions are in place.
- There is evidence that links social inclusion with recovery/relapse prevention for those with severe mental illness.
- In a recent study in New Zealand, participants cited family and friends as the most important factor in their successful recovery. By contrast, a large-scale study conducted in the UK revealed that low social supports increased the risk of onset and decreased the chance of recovery.²⁵
- A recent study on recovery and place concluded that supported housing is an integral part of a community-based recovery-focused service system.²⁶
- MHCC argue that employment provides the most compelling evidence of the link between social inclusion and recovery, citing studies that associate paid work with reduced psychiatric symptoms, higher functioning, improved sense of self worth, and significant improvement in social skills. MHCC add that whilst employment is not an option for everybody, the evidence still points to strong links between having a vocation in life, a sense of purpose, and recovery.²⁷
- Waghorn and Lloyd similarly argue that employment is a necessary condition for truly independent community living and a platform from which people with severe mental illness can obtain the rewarding aspects of life that others take for granted. They also note the strong association between education and opportunities for greater social inclusion (e.g. social networks, employment, financial security, and housing stability).²⁸

²⁵ See Merton and Bateman, op. cit., p. 9.

²⁶ Chesters J, Fletcher M and Jones R (2005) 'Mental illness recovery and place' in *Australian e-Journal for the Advancement of Mental Health*, 4:2. See *Housing and Support – A Platform for Recovery. Background Paper* for more on housing.

²⁷ Merton and Bateman, op. cit., p. 26. See *Economic Participation: Employment and Education – Changing Outcomes. Background Paper* for more on employment and education.

²⁸ Waghorn G and Lloyd C (2005) *The Employment of People with Mental Illness*, Discussion Document, Marlestone SA: Mental Health Fellowship of Australia. See *Economic Participation: Employment and Education – Changing Outcomes. Background Paper* for more on employment and education.

The cost benefits

There is compelling evidence for the cost benefits of increasing community-based supports that address the 'whole of life' needs of consumers and thereby foster greater inclusivity.²⁹ Currently, the cost of treatment is extremely high, with bed-based hospital care the main driver/contributor. Carr et al., in their study of the costs of psychosis, conclude that a disproportionate amount of money is spent on people being 'housed' (often repeatedly) in hospital (and prison); and that considerable savings could be made if we invested in evidence-based interventions to address core exclusions such as unemployment and unmet needs for stable housing. For example:

- Increased participation in meaningful vocational activities by just 10.0% of unemployed people with psychosis could potentially save society around \$147 million per annum. If the rate of participation was to increase by 30.0%, the savings would be in the order of \$441 million per annum. There are net cost benefits even if the investment in rehabilitation programs required to improve participation rates is taken into account—particularly for a 30.0% improvement.³⁰
- The estimated average recurrent cost of providing one mental health hospital bed is around \$150,000 per year (2002-2003 figure) compared to one unit of public housing at \$5,990 per year (2006-2007 figure).³¹

Looking after carers

Carers of people with serious mental illness also experience poor outcomes. Carers (most often partners or mothers) play a critical role in community-based care. A recent study shows that carers, on average, contribute over 100 hours per week caring for a person with a mental illness.³² Caring at such a level can place considerable strain on carers who typically overlook their own needs. Carers are themselves at risk of physical and mental health problems, often experiencing feelings of isolation, anxiety, guilt, helplessness, and sometimes fear for their own safety.³³

Looking after carers can be done in community-based settings.³⁴ Respite provides carers with the time, space, and peace of mind to ensure their health and wellbeing. Information, education, training, peer support, and linkages to services also make a positive difference.

A comprehensive, integrated and accessible network of supports for carers ultimately means better outcomes, not only for themselves but also for those they care for.

²⁹ The term, 'whole of life' is borrowed from MHCC. See Merton and Bateman, op. cit.

³⁰ See *Economic Participation: Employment and Education – Changing Outcomes. Background Paper* for details.

³¹ See *Housing and Support – A Platform for Recovery. Background Paper* for details.

³² ARAFMI NSW (2005), *Carer Services Mapping Project*, Report for NSW Government Department of Health, as cited in Merton and Bateman, op. cit., p. 14.

³³ Merton and Bateman, op. cit., p. 14.

³⁴ Ibid.

What do we need to build social inclusion?

There is a strong body of experience and evidence that indicates a proactive combination of strategies will address barriers and promote social inclusion. The necessary strategies include:

- Partnerships between different levels of government (federal, state/territory and local) and across different departments (e.g. mental health, health, justice, housing, employment and education).
- Investment in evidence-based community supports for early intervention, recovery, and relapse prevention in order to rebalance the current (over)emphasis on a crisis-driven acute-based mental health service system.
- Integrated service delivery and improved multidisciplinary care.
- Engagement of consumers, carers and families in developing policies related to treatment and care.
- Recognition of and investment in evidence-based peer support models that support the journey of recovery.
- Better understanding and recognition of the roles of carers (including adult family members, children, and others) and investment in supports that meet their specific and changing needs.
- Responsiveness to the unique needs of individuals along multiple and intersecting axes of differences e.g. gender, age, ethnicity, language, culture, indigeneity, age of onset, stage and type of illness etc.—that is a comprehensive understanding of, and approach to, diversity.
- Development of a social inclusion and mental health research agenda.
- Investment in evidence-based community awareness raising and education initiatives, demonstrating the links between social inclusion and recovery/relapse prevention.