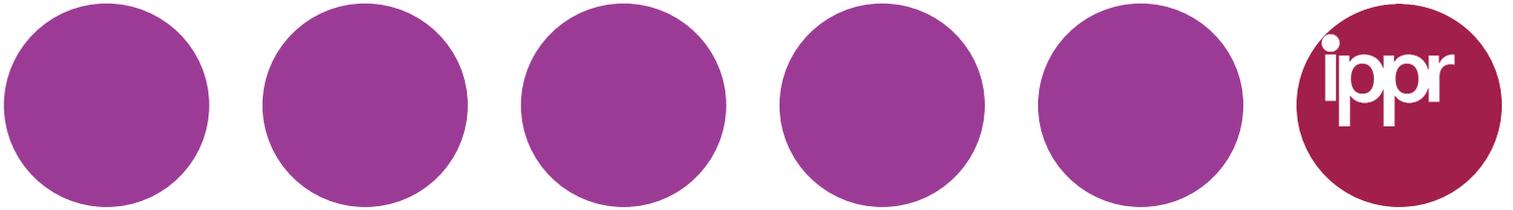


Mental Health in the Mainstream



Mental health and social inclusion

JENNIFER RANKIN

WORKING PAPER **TWO**

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Mental Health in the Mainstream
Working Paper Two

Jennifer Rankin

Contents

About Mental Health in the Mainstream	7
Scope of the project	7
About the author	8
Introduction	9
Employment	12
Community networks	15
Carers	18
Conclusion	20
References	21

About Mental Health in the Mainstream

What would it take to move towards a society that fully supports the rights and inclusion of people with mental health problems and knows the value of good mental health?

Mental health is at a crossroads. On one side mental health policy is changing in response to the new agenda of human rights, anti-discrimination and social inclusion; on the other it remains shaped by concerns over public order and risk management. Within specialist services, there are tensions between therapy and management and between greater user choice and service control. In society at large, there are emerging concerns about the state of public mental health and wellbeing which are evident in the growing concern about rising use of anti-depressants. Amid these different trends, there is no clear direction about the future of mental health.

ippr are working with Rethink on a new project that will set out a future vision for mental health policy. The main output will be an ippr report, due to be published in Spring 2005. This report will be rooted in the experience of service users and will draw on original qualitative research. The aim is to influence future developments in mental health policy, drawing lessons from policy experiences since 1990.

In the run up to this publication, ippr will publish three short working papers, with the aim of discussing some selected issues ahead of the publication of the report next year. We hope they will help engage a wide range of people in the debate. Each working paper will be a short introduction to a few key issues rather than an exhaustive study of the topic. As such, the working papers will focus on particular examples to illustrate the different themes that are shaping mental health policy:

- Working paper 1, November 2004: **Developments and Trends in Mental Health Policy**
- Working paper 2, December 2004: **Mental Health and Social Inclusion**
- Working paper 3, March 2005: **The Future of Mental Health**

In order to set priorities for the papers, ippr has worked in consultation with an external steering group. We would like to thank all the members of the steering group for their ongoing involvement in the project: Janey Antoniou, Paul Corry, Martin Knapp, Vanessa Pinfold, Dennis Preece, Cliff Prior. The author is grateful to everyone who commented on a draft of this paper, including Peter Robinson and Deborah Roche at ippr, Professor Martin Knapp at the LSE and all at Rethink; Paul Corry, Paul Farmer, Cliff Prior, Mike Took, Lucy Widenka and especially Vanessa Pinfold. Thanks also to Dr Matthew Broome at the Institute of Psychiatry for a helpful discussion on early intervention services. It goes without saying that any errors are the author's responsibility alone.

Scope of the Project

Mental health problems are more common than asthma. Up to one in six people suffer from them over the course of their lifetime, while 630,000 people have severe mental health problems at any one time, ranging from schizophrenia to deep depression. Beyond this, mental health has a far wider impact on families: there are over 1.5 million carers supporting people with mental health problems (including dementia).

As in other areas of people's lives, mental health is complicated. Mental health problems encompass a broad spectrum of experiences that affect people across the life-cycle. People do not experience mental health problems in isolation; in particular severe mental illness is frequently linked to poverty, discrimination and other complex needs. Health and social care services are demarcated by labels that mask the imprecision of people's lived experiences.

Mental Health in the Mainstream aims to reflect this diversity of experience. However, the project does focus on adults with severe mental health problems, although this will be situated within mental health issues more broadly. It is an opportunity to explore the distinction between 'severe' and 'common' mental illness, and examine the concept of public mental health. The project is primarily focused on England, but will draw on examples from the devolved countries and may be of interest beyond England.

About the author

Jennifer Rankin is a researcher in health and social care policy at the ippr. Her publications include *Meeting Complex Needs: The Future of Social Care* and *Who Cares? Building the Social Care Workforce*, she has also written for the December 2004 issue of ippr's journal *New Economy*.

Introduction

Mental health problems deny people many ordinary opportunities. It has been estimated that someone with a serious mental health problem is four times more likely than an 'average' person to have no close friends (Huxley and Thornicroft 2003). In a survey, 84 per cent of people with mental health problems reported feeling isolated, compared with 29 per cent of the general population (Mind 2004). These barriers to basic social networks signal the wider social exclusion of people with mental health problems. There is increasing understanding about the links between poor mental health and social exclusion.

Social exclusion can be defined as a series of interconnected problems around poverty, discrimination, unemployment, low skills, bad housing and poor health. By any account adults with mental health problems are one of the most excluded groups in the UK. Poor mental health is sustained by social exclusion and discrimination. As such, it has been argued that social inclusion should be the ultimate goal of a recovery-orientated health service (Sayce 2000).

There are progressive and practical imperatives for tackling social exclusion. The test of a good society lies in the care and support it offers to its most disadvantaged members. Mental illness carries heavy human costs of misery and lost opportunities. Equally, good mental health is linked with desirable outcomes, for example it is known that there are established links between social cohesion and good mental health. Communities with greater social capital can be shown to have higher levels of good mental health (White and Angus 2003).

Beyond the progressive justifications, any government would be interested in the financial ones. The Sainsbury Centre for Mental Health has set the annual cost of mental illness in the UK at £77.4 billion, taking into account mortality, increased benefit payments and missed employment opportunities (Social Exclusion Unit 2004a). The 'hidden' costs of mental illness have a significant impact on public finances: it has been estimated that the costs of depression on employment are 23 times larger than the costs to the health service (Knapp 2003). Other hidden costs of mental illness fall on family members and friends who give unpaid care and support. In the UK, there are over 1.5 million people involved in caring for people with mental health problems (including dementia) (Arksey 2002).

Despite the well known human and financial costs of mental illness, so far there have been few inroads into the social exclusion and stigmatisation of people with mental health problems. In 2004, the Social Exclusion Unit (SEU) concluded that people with mental health problems were amongst those groups that had seen the least benefits from various policies to tackle disadvantage (SEU 2004b). It is worth noting that these policies have also failed to reach some minority ethnic groups. The prospects of a person from an minority ethnic background with a mental health problem are jeopardised by a double burden of disadvantage and discrimination. The experience of Afro-Caribbean men with mental health problems reveals this dual exclusion: they are overrepresented on the unemployment rolls and in coercive treatment settings.

In 2004, the SEU provided a comprehensive analysis of the pernicious and enduring links between mental health and social exclusion (SEU 2004a). Contained within this detailed report were two important messages. Firstly, just 24 per cent of people with long-term mental health problems are in work, despite the fact that many more want to work. This is the lowest employment rate for any of the main groups of disabled people. Secondly, mental health has not benefited from the same progress in tackling stigma and discrimination as other areas, such as race and sexuality. The report concluded with a detailed action plan (although relatively few new resources), which is currently being developed under the lead responsibility of the National Institute for Mental Health in England (NIMHE).

The title of this project – Mental Health in the Mainstream – can be understood in two senses. It is about bringing people with mental illness into mainstream society, enabling access to

ordinary opportunities for employment, leisure, family and community life. But it is also about bringing 'the mainstream' to mental health, namely, bringing a tolerant and realistic understanding of mental health into mainstream society. This means having a genuine respect for difference and placing a higher value on good mental health. In practice, this should translate into greater respect and recognition for unpaid carers who support people with mental health problems.

This short paper aims to add to the momentum for change, for good mental health to become 'everybody's business', as well as a core objective for social policy. It is a short and selective study, unified around the theme of the links between mental health problems and social marginalisation. The paper considers the subject of work, because it is a key aspect of the inclusion agenda. It also looks at the role of community networks, which provide pathways to work and help give people a sense of future. It moves on to consider the different but related disadvantages experienced by some carers. Finally, the paper concludes with some recommendations for change.

Before turning to these subjects, it starts by considering two of the foundations that underpin an inclusion agenda: rights, and a new understanding of work and mental health.

Rights and mental health

Rights exist in the overlapping contexts of human rights, civil or political rights and (in an ambiguous way) welfare or social rights (Dean 2002). More and more, we hear rights as the rhetorical counterpoint of responsibilities. There is potential for all of these conceptions of rights to have a greater impact on the lives of people with mental health problems. The Human Rights Act has the potential to shape the provision of public services, for example by ensuring that services guarantee dignity and respect to the individual.¹ In terms of mental health, this would have various practical implications, from preventing unnecessary force in secure settings to guaranteeing privacy in hospital wards. Generally, the Human Rights Act has not impacted on the way services are run in the public and voluntary sector (Butler 2004, BIHR 2002). In future, the development of a 'culture of human rights' could help shift the balance from viewing people as patients, to viewing them as citizens.

The Disability Rights Commission (DRC) is already playing an important role in enforcing civil/political rights and welfare/social rights, so that people with mental health problems can participate as equal citizens. Its campaigns range from fair treatment at work, to equal access, to public transport concessions. The DRC aims to challenge the position of mental health as 'the unpalatable face of disability' (DRC 2003). However, it recognises there is not enough awareness among service users about the anti discrimination provisions of the Disability Discrimination Act. Part of the problem is that people with mental health problems do not always demand change, because of the associated stigma. Still, in the view of one advocate for change, the Disability Discrimination Act offers a more powerful tool for change than the more NHS orientated National Service Framework (NSF) (Sayce 2000).

In bringing mental health into the mainstream there are important lessons to learn from equal rights campaigns led by people with physical disabilities. The stress on empowered individuals, the importance of making choices, and the centrality of the social model all have resonance for people with mental health problems. In future a single equalities body could help join up anti discrimination measures for those facing complex discrimination and exclusion.

Welfare rights exist in a limited sense in the UK: for example no one has the right to a job or a home, although subsistence is guaranteed by the social security system. However there is growing interest in developing basic minimum incomes to guarantee healthy living. A

¹ The Human Rights Act (1998) guaranteed the freedoms and rights of the European Convention on Human Rights (ECHR) in UK law.

minimum income for healthy living (MIHL) would guarantee a healthy standard of living for people (Morris and Deeming 2004). This would have an impact on anyone experiencing poverty and poor health who is prevented from participating in mainstream activities.

Defining work and meaningful activity

Traditionally work was understood to be full-time, paid employment. It was a view that rendered unpaid commitments in the family or community largely invisible. Nowadays, this old-fashioned narrative has come away from its moorings. Increasingly it is accepted that work encompasses other forms of meaningful activity, from unpaid domestic work and caring duties to voluntary work, as well as part-time and full-time paid work. Meaningful activity itself is even broader; it includes education and skills development. But despite our broadening view on work, there remains a need for greater social acknowledgment of the full spectrum of work and meaningful activity. This is necessary if society is to value all contributions.

In the past ippr has argued that we need 'a new account of disability and work', which acknowledges disability as a mainstream issue that affects millions of people. Disability is also a dynamic experience and there is no hard and fast distinction between disabled and non-disabled people (Stanley and Regan 2003).

Within this account there needs to be a better understanding of work and mental health that emphasises rights and recovery. A fact which is often overlooked in the popular discourse on mental health is that the majority of people who experience mental illness can and do recover, although the condition may fluctuate. But recovery needs support. For many people, there is no straight road to employment. The nature of mental illness is episodic, and people need support in building up to and maintaining work. At the moment the benefits system does not reflect this and making the transition from benefits to work has been likened to jumping off a cliff.

For a minority of people with mental health problems, paid employment will not be appropriate. The dominance of an employment focus means less attention has been paid to the needs of people who cannot work at the current time. It is important to start with the presumption that everyone can work. But what really matters is some form of meaningful activity: something to do and someone to do it with (Rankin and Regan 2004). Many people with mental health problems want to build up to paid employment by being involved in other forms of meaningful activity, such as voluntary work, education or organised community activities. Ultimately, there are many paths towards recovery.

Employment

Whilst the Government's approach to tackling exclusion has been multifaceted, a key part of the agenda has been based around inclusion through work. This pre-occupation with work is evident at the top of the Government: the Prime Minister has discussed options for increasing the rate of employment and bringing down spending on incapacity benefit (IB) (Blair 2004). In 2004, there were 2.7 million people claiming IB; one third of claimants had mental or behavioural problems (Department for Work and Pensions 2004).

The Government's aim of increasing the employment rate overlaps with people's own aspirations. People with mental health problems see work as helping them recover an ordinary life. It is clear that participating in work has a therapeutic value, as well as indicating a successful outcome (Boardman 2003).

Yet, there is a substantial gap between people's aspirations and opportunities. Although people with mental health problems have the highest 'want to work rate' among disabled groups, they have the lowest actual work rate. Statistics show that whilst 52 per cent of all disabled people want to work, this figure rises to 78 per cent of people with 'depression and nerves' and 86 per cent with 'mental illness, phobias and panics' (cited in Stanley and Maxwell 2004). Evidence from America suggests that between 60 and 70 per cent of people with severe mental illness want to work in competitive employment (Bond et al 2001). However, just 24 per cent of people with long-term mental health problems actually do work.

This represents a serious policy problem. It is not a problem of knowledge, as there is plenty of evidence about what works. Randomised control studies have shown that supported employment – 'the place and train model' – is more effective than pre-work training in helping people obtain competitive employment (Crowther et al 2001, Bond et al 2001). If the problem is not evidence, it can instead be explained by the complex, multiple barriers that prevent people from taking up work. These barriers have been discussed in many accounts.

What prevents people working?

- Symptoms of mental illness and side effects of treatment
- Inflexible benefit system
- Individual's fear of failure and low expectations
- Lack of qualifications due to interrupted education
- Lack of life skills, for example timekeeping and money skills, due to disrupted adolescence
- Stigma and discrimination amongst the mental health workforce, as well as employers and society
- Employers' lack of practical knowledge in dealing with mental health problems
- Lack of awareness of rights under the Disability Discrimination Act
- Low level of resources for job brokerage services and job retention support
- Additional barriers, such as problems posed by lone parenthood or racial prejudice.

This paper singles out three reasons are singled out for particular emphasis: the benefit system, the low priority that has been given to job brokerage services, and barriers within the employment market.

Research by ippr has suggested that there is an inconsistency at the heart of IB. On the one hand, individuals must demonstrate their incapacity for work to be eligible for IB; on the other they are required to attend an interview discussing how they might work. This leads to uncertainty, risk aversion and confusion (Stanley et al 2004). People with mental health

problems face added difficulties because they have fluctuating conditions, which the inflexible rules of IB are not always able to accommodate. Permitted work rules are not always well suited to supporting people with mental health problems move into work.² The period of 52 weeks may be too short for some people to make the transition from permitted work to full-time employment. As such, it can put unnecessary pressure on people to move to full-time employment, and may lead to stress, undermining progress in work and recovery. Furthermore, despite linking rules permitting people to go back onto benefit at the old rate, in practice people have problems getting benefits reinstated (Citizens Advice Bureau 2004).³

Another important factor is that there is no comprehensive job brokerage system linked to the NHS health and social care system. The health and social care system has tended to focus on individual illnesses or problems rather than people's whole needs. So, despite some important exceptions, the NHS lacks a strong tradition of vocational rehabilitation. Although the NSF suggests implicit support for work, it does not direct emphasis towards employment schemes (Boardman 2003). Outside the NHS, government initiatives to promote work for disabled people have had a low take up so far. These include the New Deal for Disabled people and (the pilot) of Pathways to Work.⁴ This is partly related to the limited size of labour market programmes in the UK, which have not been a spending priority. In 2001/02 the UK spent 0.02 per cent of Gross Domestic Product on labour market programmes for all disabled people. This is low compared with other European countries; the EU average is 0.11 per cent, whilst Sweden, at the top of the table, spent 0.49 per cent (Stanley and Maxwell 2004). Support in employment for people with mental health problems has yet to be attempted on a large scale.

The workplace also presents substantial barriers to people with mental health problems who want to take up employment. Stigma and discrimination remain common. People with mental health problems are one of the least favoured groups for employment: in 2001 fewer than four in ten employers said they would consider employing someone with mental health problems (SEU 2004a). Traditionally, getting people with mental health problems into work involved getting the person to fit the workplace. Increasingly, a new approach is focused on making the workplace fit the person. At the moment, this approach is observed in theory rather than practice. Most employers do not have a mental health management plan and are not ready to support people with mental health problems. Around half of line managers feel they lack adequate information to manage people with mental health problems (Diffley 2003).

A strategy on work

This is an extremely limited survey of the evidence, but it could be used to suggest three complementary solutions to help promote work for people with mental health problems.

Reform incapacity benefit

Elsewhere, ippr has recommended comprehensive reforms to the current system of IB by replacing it with an earnings replacement allowance (ERA).⁵ This would de-couple incapacity from disability by indicating a replacement basic income, rather than a payment for health problems or disability. Such a reform seems particularly appropriate for mental health, where many people want to work. ERA would be paid at a flat rate, which would help

² Permitted work is allowed for people getting IB in some circumstances: (a) people can earn £20 a week for an unlimited period; (b) people can work for less than 16 hours a week, with earnings up to £78 a week after deductions, for a 26 week period. This can be extended for a further 26 weeks if the person is working with a specified job broker. After 52 weeks of permitted work, a further 52 weeks must elapse before permitted work can take place again.

³ The linking rules mean that a person who is unable to work within 52 weeks of leaving benefits may return to benefits at the same rate as before.

⁴ The New Deal for Disabled People began in 1998. Participation is voluntary and people are encouraged to contact job brokers at Job Centre Plus. The Pathways to Work pilots began in October 2003. Key features include compulsory work-focused interviews with personal advisers, with sanctions for non-attendance; access to NHS rehabilitation; strong partnerships with the New Deal for Disabled People; work with local GPs and employers; return to work credits for people moving into low paid jobs.

⁵ See Stanley and Maxwell (2004) for a full discussion of the ERA and its proposed advantages over the current IB arrangements.

clear the existing confusion around the linking rules. This would also make the move into work feel less risky (Stanley and Maxwell 2004).

The ERA would need to be more responsive to the particular issues around mental health than IB has been. It would need to take better account of the fluctuating nature of mental health problems. Permitted work rules could be adapted so that people are able to do part-time permitted work and be eligible for certain benefits beyond a period of 52 weeks. In this more flexible model, the benefit system would be more like steps that people can go up and down rather than a 'cliff' where people can have trouble returning to benefits. The pathway back to work would vary according to each individual's problems and existing skills. This demands a highly personalised system of job brokerage, where job advisers work with people on a case by case basis to plan the best route to work.

A comprehensive job brokerage system

At the moment, NIMHE is charged with working towards the goal of a personal employment adviser for everyone with severe mental illness. This is an important ambition for services, but is likely to require new resources in order to train job brokers and NHS staff. It has been estimated that it would cost £500 million to roll out the Pathways to Work pilot (which covers all disability) on a national scale (Stanley and Maxwell 2004). The pilot is a promising model, because it includes access to a personal adviser, work readiness support and support in employment. Case study 1 (below) suggests how work readiness support works in practice.

An adequately funded programme to promote anti-discrimination and practical knowledge in employment

The Government has highlighted tackling stigma as an important part of the strategy for mental health (SEU 2004a, Department of Health 1999). A key component of this strategy needs to be a programme directed towards employers and the workplace. However it is important not to bundle all problems into the bracket of stigma (though this issue is undoubtedly important). Some issues are as basic as a lack of information and practical support. Discussions with people involved in community projects indicate that new employers need more facts about mental health and practical information on supporting people at work. Some practical steps include wider dissemination of guidance on mental health, such as the *Line Manager's Guide to Mental Health* produced by Mindout for Mental Health. Guidance should include advice on what might constitute reasonable adjustments under the Disability Discrimination Act. Clients on supported employment schemes have found that helpful adjustments were flexible hours and patterns of work (Secker 2000).

Case study 1:

Confidence in Employment at Rethink East Midlands' Project Office

Confidence in Employment is one element of the Pathways to Work pilot in Derbyshire. People who are registered on the pilot attend a compulsory meeting with an IB personal adviser. They have access to cognitive behavioural therapy (CBT), as well as other services to help manage their lives, including Confidence in Employment.

Confidence in Employment is a voluntary, six day course over three weeks, which is designed to help people prepare for employment. It is aimed at people with 'mild to moderate mental health problems', although in practice this definition covers a wide variety of experiences. The course focuses on helping people manage their mental health problems and prepare for employment. It introduces people to volunteering and helps them to balance work with other activities such as exercise and a social life. Described as 'helping people to speak for themselves', the course aims to develop lateral thinking, self esteem and assertiveness. It helps individuals find ways to present mental health problems, for example thinking about appropriate language and strategies when discussing mental health with employers.

Community networks

For many people with mental health problems the first step to recovery may precede formal employment. It might be building structured days through voluntary work, or education and training. Organised community networks play an important role in getting people involved in different kinds of meaningful activity and giving them a sense of possibility about the future.

People with severe mental illness are likely to be doing nothing and pass their days in solitary, 'passive leisure' pursuits (Shimitras et al 2003). In contrast, people engaged in structured and creative activity on average have fewer readmissions to psychiatric hospital.

There is also evidence to suggest that community interventions and social support networks can be more effective than medication (White and Angus 2003). Service users themselves often stress the importance of neutral spaces and non-medical interventions. Of a group of service users in touch with Rethink, 10 per cent said that better/more personal relationships would be the one thing that would make the most difference to improving their quality of life (Pinfold and Corry 2003 a).

Traditionally, the day centre has been a key social support. It is worth noting that some people who attend a day centre think of it as a commitment, like work (Catty et al 2001). Day centres exist for social reasons and offer people the opportunity to participate in creative groups.

For some people they become safe havens in an unfriendly world. Early findings from an ethnographic study of people with mental health problems suggest that different organised or informal community networks can become 'safe' places, compared with 'unsafe' places in the wider community. There is a risk that voluntary social exclusion itself becomes a coping strategy for people on the margins of society (The Living Project Steering Group 2004). Community services tread a fine line between building confidence in a secure environment and presenting people with opportunities to become more involved in mainstream society.

The conventional approach to day services has been criticised by campaigners. There is evidence that people's wider needs can be ignored, such as physical health and aspirations to move beyond the day centre. At worst, people's recovery is suspended, and they become further adrift from mainstream community (Clark 2001).

Day centres can be predictable and routine: in one survey of time use, people attending day centres had on average significantly more undescribed time use than the population as a whole (Shimitras et al 2003). Service users themselves have mixed feelings about day care. Whilst the service is often valued, people are also uncertain about how it can help with long-term ambitions around recovery and inclusion.

Nowadays the agenda for day services is concerned with building bridges to the mainstream, rather than simply offering respite or hobbies within the margins of society. There has also been a shift away from buildings. New day services are flexible according to time and place; they could be in workplaces, health centres or shopping centres. In practice, there are significant variations in modern day/community services. However there are some common features, which could be used to build up a picture of an inclusionary day centre. Case studies suggest how they are orientated to helping people develop structured days and provide social support.⁶

⁶ The Social Exclusion Unit (2004b) report contains many interesting and instructive case studies. The decision was taken not to reproduce these examples.

New model of day and community services

- Flexible hours
- Flexible location
- Responsive and adaptable to complex needs
- Culturally and ethnically sensitive
- Supporting people in everyday life and wider integration into the community
- Strong community links

Case study 2: Social Link

Social Link is part of the North London Community Housing Association. It works with clients with severe and enduring mental health problems who are on the Care Programme Approach (CPA). At any one time, a team of personal advisers offers 150 people floating support in rebuilding structure into their lives. This includes getting people on training courses or helping them find voluntary work activities that relate to their interests.

Like other day support services, Social Link aims to be responsive to people's needs; in one case this meant helping an individual with an interest in horse-racing to get work experience in a local race track.

<http://www.communityhousing.org.uk/templates/index.cfm>

Case study 3: Resource at Reading

Resource – the Reading Mental Health Resource Centre – offers its members work opportunities, support and training for paid work, as well as a place to socialise and meet people. There is a deliberately small number of paid staff, so the centre relies on volunteers as well as paid staff to plan and run the service. Resource also aims to make connections with groups who may not ordinarily come into contact with the service, such as Afro-Caribbean people with mental health problems.

Resource was founded in 2001 and has over 600 members. Since 2001 more than 48 people have returned to paid work and 80 people have taken up internal employment, with many others participating in training programmes and social activities.

<http://www.resource.uk.net>

Case study 4: The 999 Club, Deptford

The 999 Club offers friendship, help and advice to disadvantaged people in south London. From one building in Deptford, the club offers facilities that are open to the whole community, including a café, as well as dance, exercise and relaxation classes. It also takes referrals from GPs, community mental health teams, hospitals, the police, prisons, courts and other agencies to provide support for people with varying levels of complex needs, such as mental health problems, substance misuse and poverty.

It was started in 1992 and offers both immediate help with any situation and long-term support. It is staffed by local people and helps more than 1000 people a year, but the community as a whole makes use of the facilities.

<http://www.999club.org/index.htm>

Case studies suggest that there is no single model for day service provision. What is important is that they are designed and delivered by the local community to meet local needs. In the past ippr has recommended connected care centres – one stop shops for people with complex needs who live in deprived neighbourhoods. Complex needs may include mental health problems that co-exist with housing needs, skills deficits and absence of meaningful activity. These types of centres could provide a complicated intervention through health and social care services. But they could also provide something as simple (and as difficult to find) as someone to talk to. To be accessible, people would not need referrals to access them and they would be a visible part of the community (Rankin and Regan 2004).

Day services cannot afford to become employment bureaux; they need to have a clear mission to support people in all aspects of their lives. However, they should offer people support and guidance with employment and develop links with local employers. They should be hubs to support ‘meaningful activity’ in all senses: all kinds of work, social networks and leisure.

Ultimately, the design of the service will depend on what it is trying to achieve. One problematic question is whether day services should have a ‘bonding’ or a ‘bridging’ function: i.e. should they offer people with mental health problems a haven to share experiences, or should they offer a bridge to the ‘mainstream community’? It is likely that both will be relevant for different people with different experiences of mental health problems. But in the long run, day centres cannot afford to reinforce people’s social exclusion. Even ‘voluntary’ social exclusion needs to be challenged, because it has negative repercussions for social solidarity and welfare (Le Grand 2003). Community networks need to develop strategies to help people move on from ‘safe places’ and make bridges to the mainstream community.

Carers

It is well known that mental health problems have a far wider impact beyond the people who experience them firsthand. But arguably, less is known about how society can support people who are disadvantaged through caring. Carers may have a different, but related experience of social exclusion. Of course, the term 'carer' needs to be read with a caveat. Many mothers, fathers, brothers, sisters or partners may dislike being referred to as 'carers', a term with overtones of being another part of the professional system, rather than having a close, personal relationship. The term is used here as a shorthand to describe people whose lives are affected by caring for a person with mental illness.

It is estimated that 31 per cent of carers for people with mental health problems are involved in caring activities for at least 50 hours a week (Department of Health 2002). This information has spurred greater efforts to support carers, through carers' support plans and provision of respite care (Department of Health 2002, Department of Health 1999). But despite growing attention in health and social services, carers' needs often go unnoticed in society at large. Carers who devote significant hours to a caring role have unmet needs in personal health and employment. Obviously, these problems are not specific to carers of people with mental health problems, they indicate the wider invisibility of caring.

Carers may have their own mental health problems, and are more likely than non-carers to experience psychological distress and depression. It has been shown that there is a direct relationship between care giving and distress, independent of physical health problems, financial strains, employment status and social background (Social Policy Research Unit 2004). Carers are also disadvantaged in employment. They are more likely to work fewer hours, receive lower wages in work, and lower pensions on retirement (Seddon et al 2004, Evandrou and Glaser 2003). Two thirds of carers of working age are in paid employment, and of these, one fifth provide more than 20 hours of unpaid care in the home (Evandrou and Glaser 2003). Despite the number of people this covers, working arrangements are insufficiently flexible. For instance, one third of female carers could not adjust their work patterns once caring stopped or changed (Evandrou and Glaser 2003). These problems continue despite the fact that carers' needs are often very simple. In one survey of mental health carers in Somerset, people wanted guarantees of being able to leave work on time, opportunities to call home to reassure themselves, as well as more advice on balancing employment and caring (Ogilvie 2003).

It is true to say that the new services for carers, such as support plans, have had some impact. In one survey of carers, 47 per cent thought that carers' support services had improved in recent years (Pinfold and Corry 2003b). However, this impact may be blunted as care policies have not been fully supported by broader changes to the health, tax and benefit systems. Neither is there parity of esteem for caring alongside paid employment. There is a need for a complete and visible strategy on carers' needs. At this stage, this paper can only suggest some areas that deserve further investigation. In particular, solutions need to focus on those carers who provide a significant number of caring hours in a week.

Caring as a public health issue

There needs to be greater recognition of the relationship between care giving and health inequalities. It should be part of the agenda for promoting public mental health and reducing health inequalities (Social Policy Research Unit 2004). Closer attention to promoting carers' health, wellbeing and security would have a discernable impact on mental health problems in the UK.

Caring as a tax and benefit issue

Recognising the contribution of unpaid caring through the tax and benefit system would help contribute to a fairer deal for carers. At the moment only carers caring for 35 hours a week are entitled to pension credits. It has been argued that extending tax and pension credits to those

caring for 16 hours a week needs to be considered on the grounds of equity (Evandrou and Glaser 2003).

Support strategies in the workplace

Carers could be better supported in the workplace, through provisions such as the right to request flexible working and compassionate leave. Such provisions could be contained in better guidance for employers about reasonable adjustments for carers. Carers' support plans also need to help people combine work and caring, for example by focusing more on offering practical help, such as help with shopping.

Conclusion

What happens if we do not pursue social inclusion? Without serious efforts to promote social inclusion, people with mental health problems are likely to remain marginalised at the edges of society. Mental health will continue to exact heavy costs on individual lives, and financial costs on government. In contrast, progress on all indicators of exclusion promises a reduction in misery from mental health problems and could help shape a more socially cohesive society.

In light of the Social Exclusion Unit report (2004a), it is a promising time for change. Of course, it would be naïve to expect government to achieve inclusion alone. Local communities, media, private and voluntary sectors and private individuals all play a role in determining the success of social inclusion.

However, much will depend on government policies, and how they are implemented. This short paper has suggested some recommendations for change and/or further exploration.

- Replace incapacity benefit with an earnings replacement allowance.
- Develop a national job brokerage scheme, which can be personally tailored to people with mental health problems. Elements should include access to cognitive behavioural therapy, support with everyday living, work readiness training, and support in employment.
- Produce a programme to promote mental health in the workplace that includes practical advice on reasonable adjustments and guidance on supporting carers.
- Promote mixed models of community/day centres that are designed and delivered in the local community to promote inclusion.
- Explore options to extend tax and pension credits to more carers.
- Ensure care giving is a public health issue.

One important theme across these areas is personalisation. There should be a greater focus on individual complex needs, for example personal pathways to work and different options on community support. But, within a personalised system certain groups need to be prioritised, for example people from minority ethnic communities and people with complex needs.

As well as determining policies, governments also share responsibility for setting the tone on a public issue. Arguably, recent years have seen some inconsistent and confused messages on mental health. The proposals for the new mental health bill have raised anxieties over the possibility of restricting liberty, and have had the detrimental effect of skewing the debate on mental health towards coercion. Although this has been partly offset by other messages on inclusion, there is still a need for a more consistent narrative on mental health that emphasises recovery, rights and inclusion. The final report of this project will set out a more detailed account of what this would look like.

As the introduction stated, in order to bring people with mental health problems into the mainstream, there is a need to bring the mainstream to mental health, i.e. there needs to be a tolerant and realistic understanding of mental health. In future, the success of mental health policy should be measured by the extent to which people are able to participate in work and take up ordinary opportunities within mainstream society.

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