editorial

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Community work – a cure for stigma and social exclusion?

SUMMARY

It is possible to tackle exclusion by altering the nature of transactions between individuals and groups, including mental health services. One way to do this is to cultivate 'social capital' or interdependence between individuals and groups – as well as giving, each is entitled, but not compelled, to claim something in return. It is difficult, if not impossible, to sustain stigma and social exclusion when people are meeting mutual needs, building trust and helping each other. Mental health providers can foster social capital by creating community cohesion, namely interdependent relationships between individuals and organisations. This approach has been put into practice in the USA, where providers assert that small investments in building social capital return many times the cost. In the UK there is evidence that community development can make a contribution to mental health but it does not fit well with conventional approaches to mental health services – it calls for different skills and a vision that is collective rather than individualised.

Ten years ago, few mental health professionals had heard of social exclusion. The strong emphasis placed on problems of social exclusion and strategies for inclusion by the UK Labour government elected in 1997 generated interest in the mental health community. The term is understood to have originated in France[1] and is alleged to have been adopted by the Thatcher government as a more acceptable phrase than 'poverty'; it has become a mantra of New Labour. An influential report commissioned by the government Social Exclusion Unit[2] looked explicitly at mental health and social exclusion, and has been followed by action plans and guidelines to reduce exclusion.

Social exclusion

What is meant by social exclusion? Efforts to operationalise and measure the concept are complicated by the fact that it is not a clear-cut concept but rather a discourse, a term used by social scientists to describe communication that involves specialised knowledge of various kinds.

Four dimensions of specialised knowledge are implicit in discourse around social exclusion, as used in social science and health policy.[3] First, the term expresses relative disadvantage – there are no absolute measures of social exclusion but the threshold for exclusion is determined by the structures and expectations of society. As these change, the population of the excluded alters. Fifty years ago not having a car/fridge/telephone was fairly common, but today a household without access to these things is likely to be socially excluded.

Second, social exclusion is usually multifactorial – being socially excluded conveys disadvantage in more than one respect. A homeless person has no fixed abode but a socially excluded homeless person is understood also to lack access to a bank account, social security benefits and contact with family, for instance.

Third, social exclusion is dynamic, meaning that the situation of an excluded person can change. This potential for amelioration makes social exclusion a frequent focus for government interventions.

In keeping with widespread initiatives to reduce social exclusion, the aspiration of mental health services is broadly to combat exclusion. Taking the first three dimensions of exclusion outlined here, this requires helping people with mental health problems to become more equal, tackling the multiple disadvantages that are experienced by service users (including physical health, poverty, joblessness, lack of educational achievement) and providing continuity of care for people in case their circumstances change. The fourth dimension of social exclusion is rarely acknowledged, although it is implicit in the word 'social'. This is the transactional dimension of social exclusion, the fact that social exclusion is a two-way street.[3]

How does social exclusion work?
Transactional and institutional exclusion

With the exception of members of separatist groups who are arguably closely bonded within themselves, and a minority of antisocial individuals, most people do not exclude themselves; others are involved in their exclusion,

actively or passively. Individuals and groups, in seeking their own interests, tend to exclude other individuals and groups. Sometimes this is deliberate and widely sanctioned, such as when people who kill are excluded through the legal system from the mainstream of society. However, social exclusion is often caused when the actions of dominant members of society create and sustain disadvantage through discrimination or prejudice. This is fundamentally linked to unequal power and it can be almost inadvertent. One example is the 'institutional racism' identified in the police by the McPherson inquiry.[4]

Once recognised, the implications of transactional or institutional exclusion can be seen to be far-reaching. In the case of people with mental health problems this is manifested as widespread and systematic shunning, sometimes called stigma. Stigma is a form of social exclusion whose transactional dimension is particularly evident: 'stigma exists when elements of labelling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them.'[5] The transactional aspect of social exclusion may be particularly difficult for providers of mental healthcare to address, because it stresses the role of powerful individuals and organisations in creating and maintaining exclusion. By definition, therefore, perpetrators of exclusion include mental health professionals and services, as well as others who lie outside the healthcare arena.

Recognition of the detrimental impact of stigma and other forms of exclusion demands a high level of 'organisational self-awareness', which may be expressed in anti-discriminatory policies and practices. A transactional understanding of social exclusion can assist this process of organisational self-criticism by highlighting the significance of the interactions occurring between people with mental health problems and the individuals or groups that create and maintain exclusion. It draws attention to the fact that this is a two-way process, in which power plays a part. In health services, 'governance' mechanisms are deployed to legitimate the exercise of power: 'The term governance refers to the overall exercise of power in a corporate, voluntary or state context. It covers action by executive bodies, assemblies (for example, national parliaments) and judicial bodies.'[6] However, governance is only the one facet of a complex power play in mental healthcare that reinforces stigma but is rarely acknowledged.

Reducing exclusion

Let us assume that the desire to reduce exclusion leads an organisation or an individual to the point where the focus falls on transactions between excluded individuals and the excluders. How can organisational operations and individual behaviour be altered to foster equality, trust and inclusion? When trying to achieve change, doing something positive is often easier and more effective than refraining from something undesirable. In this case, rooting out exclusion, a negative thing, may be more difficult than creating systems that will sustain and

reinforce inclusive attitudes. What positive steps might be taken?

Social capital

Another discourse comes to the rescue here, one resting on a rich vein of sociological theory – social capital. Social capital is sometimes seen in terms of close relationships ('bonds'), sometimes in terms of looser links to other people or organisations ('bridges') and sometimes in terms of group affiliation.[7] People can increase their social capital by making friends and by extending the network of people whom they can call on for help in meeting practical and emotional needs. They can also grow their capital by participating in clubs, societies and political organisations. 'Stocks' of social capital are earned and spent through the give and take of daily life. It is a non-material asset that can have material benefits and although it cannot be observed directly, social capital may be measured in terms of trust and social networks between individuals.

Sometimes the obligations associated with high levels of social capital can be oppressive, both for members of highly bonded groups, when they are burdened with many obligations, and for people who are excluded from such groups if the latter adopt an oppressive stance. However, in contemporary Western democratic society, the best evidence is that on balance high social capital is beneficial for an individual's mental well-being.[8]

Organisations also have social capital, in the form of inter-agency good will, a history of cooperation, recognition of shared aims and mutual trust. These factors mean that the agencies concerned can work together with less friction than might otherwise arise. Organisations amass social capital by operating transparently, communicating their mission and being socially responsible. They foster it by reaching out, to community and voluntary bodies, business associations and other groups whose interests coincide with their own. The reciprocal nature of this process should not be forgotten – as well as giving its expertise, time or facilities, the organisation is entitled to claim something in return to promote its own objectives.

The analysis presented here implies that the creation of social capital is antithetical to the maintenance of social exclusion. Building social capital means creating links between individuals and organisations that entitle them to make claims of each other. When neighbours borrow and lend they treat each other as equals. Asking another person for advice shows that you trust and respect them. Finally, members of a club or association focus on common aims, regardless of the things that make them different. Thus it is difficult, if not impossible, to sustain social exclusion when people are engaging voluntarily around meeting mutual needs, building trust and helping each other.

This is why focusing on the creation of social capital by engaging with individuals and groups outside mental health services could supply a remedy for stigma and social exclusion. Defeating stigma through community

engagement is also compatible with a recovery ethos because it aims to create an environment where recovery is sustained naturally. The key point about this approach to fostering positive transactions between service users and the wider community is that it requires a give-and-take approach. This inhibits exclusionary tendencies because it promotes equality and interdependence. 'Community engagement' is given a more specialised meaning by the National Institute for Health and Clinical Excellence in relation to health improvement. In the public health guidance it is defined as 'the process of getting communities involved in decisions that affect them'.[6] Community engagement is threatening to some powerful people, because mental health services which acknowledge interdependence cannot offer a refuge for people who prefer the 'us' and 'them' approach, or those who operate a care ethos which individualises problems, irrespective of their family and community contexts.

Fostering interdependence in mental healthcare

What mechanisms might make interdependence a reality for mental health services and their consumers? There is a lot still to learn, but some examples are found in the USA and in the UK. Utilising community resources has been put into practice explicitly by some mental healthcare providers in the USA. Working in entrepreneurial ways to build community partnerships, they have successfully tapped community assets by being proactive in pursuit of social capital. As a result, the consumers of these mental health services enjoy wider acceptance and greater opportunities to lead normal lives.

Academics have begun to document the approaches used. At the University of Pennsylvania, USA, they call the process 'community integration'. Richard Baron has written a compendium of local strategies (available online at www.upennrrtc.org) that lists 20 approaches to community integration, devised by 10 behavioural healthcare providers in Pennsylvania. These include an assortment of activities such as promoting volunteering, employment, education, social engagement, housing support, and religious and spiritual connections. Alternatively, a provider in Massachusetts that has taken the idea of community engagement to heart provides bridging grants to fund initiatives that develop interdependent relationships among different people and organisations. These have been awarded to theatre groups, art exhibitions and community gardens, among others. Their approach is to start from where the community finds itself, identify its 'passions' and build these into joint projects where everyone wins.

One obstacle to establishing an evidence base for such innovations is that they are often targeted at groups. When the focus of intervention is the group, then the outcomes of interest need to be measured at the level of the community as a whole. This poses a challenge for evaluation, since conventional approaches are dominated by individual metrics. Another consideration in targeting community development are the skills required:

developing linkages with community resources; integrating resources into outcomes; promoting the use of natural supports; challenging discriminatory situations; connecting people to advocacy resources; and developing community resources. These skills may be in short supply in mental health services. The recruitment of community development workers with specific responsibility for creating and maintaining networks with Black and minority ethnic groups through the 'Delivering Race Equality' agenda[9] is beginning to attract relevant skills to the National Health Service, although this small number of non-traditionally qualified staff may be in danger of being overwhelmed by the mental healthcare 'establishment'.

Community work in the UK

A recent survey of community work initiatives in mental health services in the UK, *Connect and Include*,[10] highlights significant activity which attracts little attention from conventional mental health services. In the Executive Summary, the authors describe community work in mental health as 'opening up ways of talking about mental health to increase understanding and reduce stigma; making links between local people and their public services; improving public services; and developing new opportunities and activities including community-led resources'. They locate such interventions, with their ethos of partnership and empowerment, squarely in the context of the recovery approach to mental healthcare: 'There is an emphasis on gaining control, good relationships and personal fulfilment which have relevance for the wider community, many of whom feel oppressed by the economic, social and emotional pressures in their daily lives.' They portray community well-being as 'thriving, not just surviving', and stress the interdependence between the individual with mental health problems and other members of society, noting that such attitudes are compatible with health and social care principles of choice, empowerment and social inclusion. The survey supplies a wealth of information that could guide development, demonstrating that the proactive construction of community partnerships is feasible.

Conclusions

Community engagement appears to be a low-risk strategy and relatively low in cost. Its predicted outcomes include lower stigmatisation of people with mental health problems and greater social cohesion in given communities. Communities may be local and geographically defined or they may be virtual ones, defined by affiliations or chosen membership. As long as they offer equality and acceptance, the arguments and evidence assembled here indicate that they will promote recovery for service users and the mental well-being of the whole community. Anti-stigma initiatives such as the 'Time to Change' campaign draw attention to the interface between mental health service users and the wider

editorial

community. Sustaining change will demand a re-engineering of the relationships between mental health services, their users and the communities to which they belong.

Acknowledgements

Patience Seebohm helpfully commented on this paper.

Declaration of interest

None.

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284