

# **RETURNING CITIZENS: SOCIAL INCLUSION AND OCCUPATIONAL JUSTICE FOR MENTAL HEALTH SERVICE USERS**

*Reintegrando Cidadãos: A Inclusão Social e Justiça Ocupacional para os Usuários do Serviço de Saúde Mental*

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Artigo encaminhado: 20/11/2016  
Aceito para publicação: 20/02/2017

**ABSTRACT:** This paper argues that social inclusion for service users can be enhanced through occupational justice and the protection of their rights as citizens to have meaningful employment. The paper will present a brief overview of citizenship and the importance of being included as a full participant in the democratic functioning of the state. The paper will then define social inclusion and what this means for people with mental health problems. The context of the current politics in the workplace and within mental health services and how this can impact on the vocational and occupational support of service users is also addressed. Empirical findings in both New Zealand and Brazil on social inclusion will be presented followed by international recommendations for future practice and policy that supports social inclusion. Initiatives in the sphere of employment for service users in both countries is also summarised. The paper will conclude by presenting the opportunities to increase the number of service user in the workforce and the impact this has on their sense of inclusion and connection on their return to the city, and their home, as citizens.

**Keywords:** *Citizenship. Employment. Mental Health Service Users. Precariat. Social Inclusion*

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**RESUMO:** Este artigo argumenta que a inclusão social para os usuários de serviços pode ser aumentada através da justiça ocupacional e da proteção de seus direitos como cidadãos para ter um emprego significativo. O artigo apresentará uma breve descrição sobre o conceito de cidadania e a importância dos usuários serem plenamente incluídos no funcionamento democrático do Estado. O artigo irá então definir a inclusão social e o que isso significa para as pessoas em sofrimento mental. O contexto da política atual no local de trabalho e nos serviços de saúde mental e como isso pode afetar o suporte profissional e ocupacional dos usuários dos serviços também é abordado. Serão apresentados resultados empíricos tanto na Nova Zelândia como no Brasil sobre inclusão social, seguidos de recomendações internacionais para futuras prática e política que apoiem a inclusão social. São também apresentadas as iniciativas no âmbito do trabalho para os usuários dos serviços em ambos os países. O artigo será concluído apresentando o aumento de oportunidades de emprego para os usuários no mercado de trabalho e o impacto que isso tem sobre eles no sentido da inclusão social e integração deles na cidade, em casa, como cidadãos.

**Palavras-chave:** Cidadania. Emprego. Usuários de Serviços de Saúde Mental. Precariedade. Inclusão Social.

## 1 INTRODUCTION

The extent to which one is included or excluded within society can determine the degree to which people feel accepted and are able to contribute as full citizens. For many marginalised groups, social inclusion can be determined by their difference from the dominant group based on their gender, sexual orientation, ethnicity or mental, intellectual and physical disability (HAMER, FINLAYSON, WARREN, 2014a; LISTER, 2007; MIRFIN-VEITH 2010). Social inclusion is thus determined by barriers and the societal and governmental structures and technologies of control within the body of citizenship that exclude and marginalise some citizens, while privileging others (FOUCAULT, 1991; PILGRIM & ROGERS, 2005).

Scholars have argued that citizenship is not a fixed state, rather it is a fluid concept and institution (ISIN, 2009; LISTER, 2004) that both dominates and empowers its subjects. Isin (2009) further argues that citizenship is in a constant state of flux in which outsiders or strangers continually redefine their *person*—their legal status, and their *persona*—being constructed as the insider and citizen, who either adopts or challenges the rules and norms

of conduct within society. The notion of inclusion within the body of citizenship suggests that a person is required to meet a set of criteria in order to acquire the status of the insider. Those citizens who do not follow the rules and norms are regarded as transgressors of the, often unwritten, rules and norms and subject to discipline and control by state institutions such as hospitals, prisons and psychiatric asylums (FOUCAULT, 1971, 1977). Therefore, the identity as a citizen confers a bundle of rights and responsibilities while also embodying a social process; a practice that requires the citizen to develop the art of being with others, able to negotiate different situations and identities, and articulating oneself as distinct from yet similar to others (ISIN et al. 2008).

Within the global North, marginalised groups have challenged the universalistic view of citizenship by lobbying for recognition of their different identities within the body of citizenship. For example, groups such as women, ethnicities, disabled people and the gender and sexually diverse people have been Othered (LISTER, 2004). Lister uses the capital 'O' in othering to denote its symbolic weight and argues that Othering is not a static state, but an on-going process perpetuated by the way the dominant group in society treat those perceived as different, creating the demarcation between "us" and "them. Whereas, the lower case 'o' denotes people as our equal 'other' and the moral obligation to take "the ultimate responsibility" to care for each other (LEVINAS, 1985, p. 119). People who are Othered are regarded as the outsider when compared with the universal figure of the citizen, perceived as the able-bodied, adult, white, heterosexual and male figure (CLARKE, 2004; LISTER, 2004). Fraser (1997, 2000) further suggests that groups socially constructed as Other are vulnerable to mal-distribution of their rights and entitlements and misrecognition of their identity, which in turn weaken their democratic participation and ability to make meaningful contributions to society.

## **2 SOCIAL EXCLUSION AND STIGMA**

People experiencing mental illness (service users) are at high risk of social exclusion (LE BOUTILLIER, CROUCHER, 2010; TWARDZICKI, 2008), resulting in their inability to secure and retain meaningful occupation and employment (LOCKETT; BENSEMAN, 2013; Mental Health Commission, 2011; NAGLE; COOK; POLATAJKO, 2002), which are integral to developing and maintaining social networks (PARR, 2007a; PARR, PHILO; BURNS, 2004; SMYTH; HARRIES; DORER, 2011).

In Australia and New Zealand, the employment rate for service users is less than 25% (LOCKETT; BENSEMANN, 2013), and in the United Kingdom it is 15% (EVANS; REPPER, 2000). Mateus et al. (2008) and Giatti, Barreto, and César (2008) suggest that unemployment figures in Brazil are also high for service users. Attempts have been made internationally to develop more inclusive policies internationally (BARNES; COELHO, 2009; European Commission, 2005; LUSS I& PEREIRA, 2011; Ministry of Health, 2012; ODPM, 2004), and to reduce stigma and discrimination (EVANS-LACKO; HENDERSON; THORNICROFT, 2003; LOCH et al., 2011; Ministry of Health, 2014; PELUSO & BLAY, 2011; THORNICROFT et al., 2013). A large proportion of people with mental health problems, however, continue to report the experience of social distancing (BAUMAN, 2007) by their co-citizens and exclusion from their right to participate fully in society.

Attitudes that perpetuate stigma, discrimination and the exclusion of service users within the health services and academia has also been widely documented (AROMAA et al., 2011; BATES & STICKLEY, 2013; BAUMANN, 2007; CALLARD et al., 2012; CORKER et al., 2013; HENDERSON et al., 2016; HIPES et al., 2016; TAL; ROE; CORRIGAN, 2007; WYNADEN et al., 2014). Hamer and Finlayson (2015) and Sayce (2015) argue that pervasive stigma and discrimination results in service users being regarded as the Other and as outsiders, leading to a wide array of injustices and conditions that interrupt service users ability to exercise their citizenship rights and responsibilities (HAMER et al. 2017) and disrupt their everyday social relationships, essential for the exercising of citizenship (WARE et al. 2007).

The government of Brazil has recently taken an important step in incorporating disability rights into its larger national human rights plans and policies. However, Mateus et al., (2008), Kirakosyan (2013) and Barnes and Coelho (2009) warn that the inclusivity of such policies and structural constraints, such as negative attitudes within Brazil towards people with disabilities, will hinder such outcomes even if the policies are successfully implemented. Similarly, in New Zealand, the negative attitudes of mental health workers towards people with mental illness have been described as increasing the social distancing and exclusion of service users (PETERSON et al., 2004, 2007; WYLLIE & BROWN, 2011; WYLLIE; CAMERON; HOWEARTH, 2008).

Siqueira et al., (2016), concur suggesting that mental health workers with lower levels of education and experience are more likely to stigmatise, and show social distance towards service users. In response, New Zealand has developed an educational programme for mental health workers to reduce stigmatising and discriminating attitudes and behaviours towards service users (TE POU & WHAKAARO NUI, 2009). These strategies aim to promote positive attitudes by mental health workers thereby supporting service users' recovery and sense of social inclusion.

### **3 SOCIAL INCLUSION AND MENTAL HEALTH**

Social inclusion can be defined as the extent to which people are confident about and able to exercise their rights and participate, by choice, in the ordinary activities of citizens (HAMER et al., 2014b). Being included and participating means that service users can access their social and economic world, participate in civic life, vote (LAWN et al., 2014; Nash, 2002), have friendships, raise a family (SAYCE, 2001), and exercise the right to dream (LISTER, 2004) of a life well lived. Social inclusion is a human right. The United Nations Convention on the Rights of Persons with Disabilities (2006) (the convention) is the first legal instrument that recognises the inherent rights of people with disabilities to have human rights protection. The convention defines disability as persons with long-term physical, mental, intellectual or sensory impairments. It also highlights the various barriers that people with disabilities face that limit their access to the civil, political and social rights of citizenship, thus hindering their full and effective participation in society on an equal basis with their fellow citizens.

Article 19 of the convention states that people with disabilities have a right to full inclusion and participation in the community. The convention also stipulates that all countries that have ratified the convention (Brazil and New Zealand are signers), must take appropriate measures to support the participation and inclusion of people with mental health problems, including physical, mental, social and vocational support. Therefore, social inclusion needs be given a greater emphasis in mental health policy, thus putting pressure on mental health workers to embrace socially inclusive practice (SAYCE, 2001, 2015). The convention also describes social inclusion and participation as civil, political

and social rights and thus matters of social justice rather than ‘health’ issues (HMERr et al., 2014b; MILNER & MIRFIN-VEICH, 2012; SAYCE, 2015).

In New Zealand, Cheer (2009) report that mental health workers can increase social inclusion for service users when they show positive attitudes, optimism, hope and confidence in service users’ capacity to recover. Hamer et al. (2014b) also found that mental health workers play vital roles as ‘champions’ in service users’ recovery journeys, helping them reverse their spiral of despair (CALLARD et al. 2012). Weller (2009), further argued that Article 25 of the convention emphasizes the need for mental health workers to have human rights training and professional ethics in order to bring a social rights orientation to practice. Mental health workers therefore can play a vital role in fostering, enhancing and supporting social inclusion for service users (British Psychological Society, 2008; DAVIDSON; FLANAGAN; STYRON, 2012; SAYCE, 2015; SMYTH et al. 2011).

#### **4 OCCUPATIONAL JUSTICE**

Occupational justice (NILSON & TOWNSEND, 2010; WILCOCK & HOCKIG, 2015) is an evolving theory, informed by social justice and the concerns for a justice of difference. It recognizes the person’s right to inclusive participation in everyday activities regardless of age, ability, gender, social class, or other differences. Yerxa (2000) has coined the term *homo occupacio* to describe the persona of the citizen as that of the self-directed, self-initiated occupational human who takes possession of his or her world through a repertoire of activities located within the rules and norms of society. Many service users who have been excluded, however, are relegated to a zone of exception as *homo sacer* (AGAMBEN, 1998, 2005), and as Fiorati et al. argued, service users become the “banned, silent and immobile” subject; a role and attribution in which the personal power of the citizen no longer holds (HAMER et al., 2017).

Wilcock and Hocking (2015) assert that occupational justice facilitates social inclusion through participating in the everyday performances; the being, the doing and becoming as the self-directed and self-initiated citizen. Regardless of one’s difference, they argue, inclusion through work, caring for, and being with others and enjoying recreational endeavours is the right of all citizens. Developing these social processes chimes with the contention by Isin et al. (2008) and Ware et al. (2007) that the everyday practices of

citizenship requires the art of being with others which fosters the person's ability to do, to be and to become the active citizen.

## **5 SOCIAL INCLUSION AND THE CITY**

Being both *in* and *of* the city (ISIN, 2002) is essential for the being, doing and becoming as a political actor. According to Isin, it is within the city that the extent of one's political power as a citizen is nestled within the norms and patterns of inclusions and exclusions. Isin further argued that the space that is objectified as the city is constituted by the social encounters of groups who assemble themselves, mobilise various forms of human capital and make claims for their rights and responsibilities as citizens. The city, therefore, is not a container where differences encounter each other; rather, the city "generates differences and assembles identities" (ISIN, 2002, p. 283). However, within the city, zones of exception exist in which the usual rules and norms of citizenship no longer apply, such as in refugee camps (DIKEN, 2004; ISIN & RYGIEL, 2007) and the rules and regulations of psychiatric institutions (GOFFMAN, 1961).

Fiorati et al. (2008), describe the "psychic suffering" of service users who were incarcerated and treated within the asylum model of care, resulting in service users' psychological fragility, their social difficulties, minimal level of quality of life and systematic expulsion from public spaces in the city. Fiorati et al. (2008) also described the social inclusion and recovery of citizenship as peoples' ability to once again "walk through the city" in which they live to reclaim their right to be included regardless of their difference. Such sentiments echo Aristotle's (1995) declaration that "the city cannot be composed of those who are like one another," requiring an assemblage of differences in order for democracy to be sustained.

It has been suggested that the evidence base for fostering the social inclusion of service users is strongest in regard to occupational activities such as volunteering or paid employment (DORER; HARRIES; MARTON, 2009; PERKINS, FARMER, LITCHFIELD, 2009). As Nagle et al. (2002) argue, employment increases social inclusion through service users' improved financial status, development of their self-confidence, and their social acceptance by others. For example, in Brazil, a number of authors have turned their attention to the role of the psychosocial community (and rehabilitation) centres (CAPS) (FIORATI; SAEKI; BELLUZZO, 2008; LUSSI & PEREIRA, 2011; MATEUS et al., 2008;

SALLES & BARROS, 2014) as a means to support the social inclusion of service users. CAPS set out to help people recently discharged after many years of hospitalization to reintegrate into their communities and to support their emancipation from psychiatric institutionalisation. The following sections focus on initiatives in Brazil and New Zealand that have attempted to increase social inclusion through employment for service users.

### **5.1 Social inclusion in Brazil**

Within the CAPS approach, Mateus et al. (2008) introduced the notion of the “return home” and reminiscent of the analogy of the offender as the ‘re-entering citizen’. Having been equally incarcerated and excluded from society for many years, social agencies have been developed to help former offenders to successfully reintegrate in and become full citizens within society (STAFF, 2016). While offenders’ rights may be withheld or suspended during their incarceration (Penal Reform International, 2016), Uggen, Manza, and Thompson (2006) argue that many “hardened” criminals become decent citizens when they have the full restoration of their citizenship rights. In contrast, offenders who have a mental illness, face a wall of resistance to being integrated back into their communities (DRAINE et al., 2005). Such a double standard places conditions on service users’ rights and shuts down their opportunities to demonstrate that they can be trustworthy and competent employees and citizens.

Following Mateus et al. (2008) lead, Lussi and Pereira (2011) developed the “social (re)insertion” programme within the CAPS approach, asserting that this will offer a social inclusion-based re-entry to the social and political life of the city by people who have experienced long psychiatric hospital admissions in institutions. Restoration of service user’s rights through the CAPS psychosocial approach helps service users to regain their identity as political actors. In so doing, CAPS attempts to create a rights-based approach to rehabilitation that invokes the spirit of article 19 of the convention and increases inclusion and participation for service users.

However, Fiorati, et al. (2008) warn that the CAPS service operates within the Brazilian capitalist State’s reliance on the medical power that perpetuates a technical-scientific orientation towards psychiatric illness that understands service users and their distress through the lens of the bio-medical model, and attributes the genesis of mental illness to a predominantly neurobiological cause (BRACKEN & THOMAS, 2001; READ;



MOSHER; BENTALL, 2004).The dominance of this orientation can exclude the fundamental factors and structural inequalities, such as gender, socio-economic status and cultural differences (O'GRADY, 2005; USSHER, 2000) that impacts on mental wellbeing, and perpetuates stigma and discrimination towards service users.

As the focus of social inclusion tends to be on getting service users involved in their city and their communities, either through work or recreational activities, it is important to consider the current context within the workplace and the impact that this has on the mental health and wellbeing of workers. Rose, Daiches, and Potier (2012) argue that social inclusion through employment must remain within the policy agendas of Nation states. However this imperative comes with a caution. Reporting on what social inclusion means to young adults, Rose et al. noted that the societal discourses of inclusion such as productivity, independence and career mindedness - imperatives for acceptance and belonging - had the potential to leave young adults feeling excluded, isolated and distressed.

The argument by Rose et al. (2012) is further supported by Turner (2001, 2006) who contended that the valued contributions by citizens, through work, public service (such as military duty) and reproduction constructs the social identities of people as “worker-citizens”, “warrior-citizens” and “parent-citizens” (2001). Both Turner and Lister (2004) warn though that minority groups have been traditionally excluded from these identities due to social and legal exclusions (e.g. gays and lesbians are excluded from military service) thereby curtailing their ability to have the same rights as other, such as employment. As a minority group unemployment is a common experience for service users, despite many wanting to work (ODPM, 2004). The subsequent erosion of service users’ status as citizens results in the loss of hope for the future, a collapse of personal agency and further decline of mental health through occupational and social injustice and oppression (HOGGETT, 2001; WRIHT, 2012).

In Brazil, Giatti et al. (2008) reported that a decline in mental health and wellbeing is common for many people when they became unemployed or engaged in precarious, informal or ‘no-contract’ jobs. Further, Standing (2012, 2014) has argued that neo-liberal labour laws are increasingly creating uncertainty about job security, coining the phrase *precariat*, a labour workforce that is increasingly marginalised and stigmatised. Recast as the lazy, directionless, undeserving and dangerous class, the precariat Standing argues,

are subject to the five A's - anger, anxiety, apathy, alienation and anomie. Regarded as an underclass, precarians move from the status of citizens to denizens where their right to have work that is stable, secure and financially beneficial is no longer assured (STANDING, 2014).

Hamer et al. (2017) argue further that for potential workers who have a psychiatric diagnosis and history of institutionalisation, returning home and re-entering the workforce puts service users in a vulnerable and paradoxical position of wanting to work yet facing the injustice of working in environments that promulgate anger, anxiety, apathy, alienation and anomie. It is argued therefore, that the philosophy of mental health service delivery requires a contextual understanding of the technologies that marginalise vulnerable people, including the precariousness of the workplace and the power of stigma and discrimination. The reflections and analysis by the authors included in this paper who have changed service delivery to acknowledge the contextual aspects of their socially inclusive services is discussed later.

## **5.2 Social inclusion in New Zealand**

A New Zealand study (HAMMER, et al., 2014b), set out to investigate the stories of successful social inclusion for service users. The authors reported that service users regarded social inclusion as a fluid concept; a subjective experience and a journey of moving in and out of inclusion-exclusion dependent on the internal and external factors in service users' personal lives and the situations they encountered. Service users spoke of having the experience of inclusion when others recognised them as equals bringing an internal sense of being *important* and of *mattering* to others. More specifically, being seen as having a valued contribution within the occupational, family and recreational spheres of everyday life increased their personal sense of being valued.

Though Hamer et al. (2014b) found that internal or self-stigma (CAVELTI et al., 2012; WATSON, 2002a; PETERSON; BARNES; DUNCAN, 2008), constituted a threat to their sense of inclusion and was counteracted by service users' journey of recovery increasing both their internal and external sense of inclusion. For example, when service users were open about their mental illness with others it reduced the social distancing. Accepting and celebrating their difference (e.g. Mad Pride music events) also reduced the internal stigma. Being consumer leaders and regarded as positive role-models for others increased their sense of power and confidence. Overall, by keeping their focus on their

*right* to be included also increased their self-confidence to take up offers of social and work related activities that strengthened their connections with others.

Hamer et al. (2014b) reported that the external factors were the positive actions and words of service users' family and friends, their peers, employers, work colleagues and mental health workers. These gestures relayed to service users that they were no different from others, thus constituting normalising and validating experiences (Peterson et al., 2004) that restored their personal power and agency as citizens. These actions were the "circuit breakers" (PETERSON; BARNES; DUNCAN, 2008) that reversed the social distancing and exclusion and increased the personal contact, which Corrigan and colleagues (2011; 2014; 2002b) argue break down the barriers inherent in stigma and discrimination and increase social inclusion.

For service users, the power of contact with people who were accepting of their difference led them to conclude that they were being recognised for their humanness, rather than being defined by their diagnosis. Hamer, et al. (2014b) contended that lifting the veil of stigma towards the other requires participatory imagination, a form of civic friendship described by Nussbaum (2010) that moves beyond empathy to a morally informed perception of the other. Nussbaum argues that by looking beyond the negative stereotypes based on our innate fear of those who are different from ourselves, we can develop the inner eyes to see the full human being. The following section will present a selection of the literature that focuses on employment as a means to increase social inclusion and the challenges faced in the attempt to increase social inclusion.

## **6 SOCIAL INCLUSION AND THE SOCIO-POLITICAL CONTEXT**

Brazilian researchers (FIORATI et al. 2008; SALLES & BARROS, 2013a, 2013b, 2014; SALLES & MATSUKURA, 2016) have offered analytical insights through the introduction of the CAPS services, aimed to increase service users' connection and social bonds to their families and in their communities. Connection and belonging, two existential aspects of social inclusion, were supported by linking service users with non-governmental organisations, secondary schools and cultural associations as a means of increasing occupational activity, and for some service users, career options.

The consensus of the latter authors suggests that this change of service delivery and practitioner behaviour brought some challenges to the service goal of social inclusion.

As Fiorati et al., (2008) have argued earlier, the Brazilian capitalist State's reliance on the technical-scientific orientation towards psychiatric illness left some of the families of service users who were returning to their homes feeling guilty and responsible for previous treatment failures. In addition, they argue that mental health workers are not immune to a technical-scientific orientation that excludes the socio-political context of mental distress, and further marginalises and excludes service user from familial bonds and opportunities to generate human capital, for example social and economic. Fiorati et al. further contend that the absence of the political and anthropological dimensions of care, leads to negative outcomes for service users. In sum, the authors warn that within Brazil's capitalist and globalised society, service users are at risk of being excluded from social spheres by virtue of being regarded as having little value within the neo-liberal marketplace when compared to other members of society.

Lussi and Pereira (2011) expand on the importance of occupation for people who are marginalised, arguing that psychiatric reform processes in Brazil must include social policies that support service users' social inclusion, including access to the marketplace through economic opportunities that support their social justice and equality. Rehabilitation programs must include modifications that attend to the power of relationships and social connection, thus ensuring occupational justice by supporting the social contribution of service users. Overall, the link between social inclusion and improved mental health and wellbeing through employment is increasingly being established (GOLD & WAGHORN, 2007; WAGHORN, 2009; WAGHORN & HIELSCHER, 2015; WAGHORN & LLOYD, 2005; WAGHORN et al., 2012). According to Waghorn and colleagues, when service users take jobs that meet their personal preference, their social inclusion and relief from poverty and diminished reliance on government welfare is achieved.

## **7 WHATWORKS: Social inclusion through employment**

At the outset, the negative attitudes of mental health workers and their ongoing institutional orientation towards treatment for service users that perpetuate social *exclusion* must be addressed (FIORATI et al., 2008; PETERSON et al., 2004). Peterson et al. report that mental health workers can negatively influence service users' employment plans by suggesting that the person not attempt a certain type of job, or encouraging them to wait until they are 'less ill'. By way of contrast, Hamer et al. (2014b) found that for many service

users, the champions for social inclusion were mental health workers that they worked alongside who held a recovery-orientated approach, an important underpinning philosophy for the delivery of post-institutional care and treatment.

A recovery approach describes both a personal journey by service users and an approach to care and treatment that underpins mental health workers' practice (Mental Health Commission, 2001). The personal journey is described as the recovery from the impact of a "reductionist and pessimistic" (O'HGAN, 2009) approach of biological psychiatry and labelling, and the restoration of the person's capacity to have hope, development of new purpose and meaning and living with the reality that you can be "ill and well" at the same time (BORG & KRISTIANEN, 2004). Of concern, the recovery philosophy has increasingly been influenced and co-opted by the dominance of a reductionist view of mental distress (Morrow, 2013) risking the "empty rhetoric" (MEEHAN, 2008) of the recovery philosophy within the practices of mental health workers. Gordon and Peterson (2015) found that transformational leadership by managers and clinicians within mental health service delivery, and employers, increased the support and employment options for service users. Tangible examples of service users actively in work will also help to change staff attitudes. Further, in order to support social inclusion and minimise the impact of oppression and marginalisation of service users (DAVIDSON, 2008), it is important that the recovery philosophy underpins psychiatric rehabilitation (DEEGAN, 1988).

In Brazil, Lussi and Pereira (2011) demonstrated socially inclusive leadership within their CAPS service by introducing the notion of employment supporters (identified mental health workers within the CAPS team) and trained employment advisors (external to the CAPS team). The authors also developed integrated cooperatives, described as social enterprises and alliances with business entrepreneurs to connect service users with the real activity of producing goods for the market. Such cooperation also separates work from the sphere of clinical care environments where the rehabilitative tools of 'clinical' industrial therapy units in the psychiatric institutions did little to raise the citizenship status of service users (HAMER et al., 2017; PARR, 2007b).

In New Zealand, Lockett (2009) and Lockett and Bensemann (2013) have recommended individual placement and support (IPS) programmes. IPS is an international evidence-based approach to employment for service users (DAVIS & RINALDI, 2004;

RINALDI et al., 2008; The Dartmouth Institute, 2016) that has outperformed traditional vocational guidance programmes in securing employment for service users. Lockett and Bensemman (2013) also argue that retaining employment is more likely when people are *trained-in-place* rather *placed-when-trained* in employment settings.

Outcomes from a randomised control trial for IPS in six European countries (BURNS et al., 2007) not only support the success of securing work for service user, but also dispels myths, asserting that people with mental illness do not become unwell due to working, and that the use of community mental health centres and admission rates to acute units drop when people gain employment. Employment outcomes are defined as securing competitive jobs open to others in the labour workforce that have permanent status; pay at least the minimum wage and are not 'sheltered' or set aside for people with disabilities (LOCKETT & BENSEMANN, 2013). Becker et al. (2007) also report that longitudinally, more than half of service users who secured employment through IPS programmes were employed for at least 50% of a ten year period Lockett (2009) stresses that the effectiveness of the IPS programme requires several key features and key personnel, particularly the importance of leadership at a strategic and operational level. The key personnel and key ingredients to successful implementation are: the employment adviser; the employment 'champion', usually an existing health professional within the clinical team; and the clinical team manager who addresses any particular concerns (and corrects any myths) that mental health workers may have. Rinaldi, Miller, and Perkins,( 2010) also recommend that these latter roles receive specialist training and supervision.

Other countries have also recommended strategies to support social inclusion via employment. The Social Exclusion Unit (2001) in the United Kingdom suggested: having programmers for reduction of stigma and discrimination that challenge negative attitudes, both in the community and in the workplace; promoting awareness of service users' rights; implementation of evidence-based practice in vocational services through partnerships between health and social care agencies; access to employment advisors and social support in primary care; redesign of mental health day services; training health and social care professionals and employment providers, and working closely working with criminal justice system staff and administrators (or the like).

Lloyd, Tse, and Deane (2006) and Nash (2002) contend that social inclusion not only offers a framework for developing mental health policy, but also serves to measure

how well mental health services are achieving recovery-orientated outcomes for service users. Lloyd et al. offer four overarching principles to increase social inclusion; to involve multiple service providers; to form alliances with and educate public media; to develop community initiatives; and to advocate for legal reforms to secure service users' rights. In sum, if these strategies discussed are successfully implemented, service user will experience increased social inclusion and the psychological and material support to find and retain work.

## **8 CONCLUSION**

Mental health service providers have many opportunities to facilitate social inclusion for the people they serve. These opportunities will arise when mental health workers balance both the technical-medical model and the recovery approach, with the aim of restoring and protecting the rights of service users to enter the workforce and take part in other vocational and recreational activities. Further, mental health workers can de-institutionalise their own practice to include the non-clinical aspects of their roles, such as working more closely with families, community organisations, educational institutions and employers to support and sustain the social inclusion of service users. Self-reflection by mental health workers on some of the institutional myths they hold about service user's ability to work also need to be challenged to reduce the stigma and discrimination within mental health settings.

Regarding the precariousness of work, service users have survived many years of psychiatric institutionalization and exclusion. With the right structural and personal support from mental health workers, who show deference to the resilience and talents of service users, it is likely that they can survive the rigours of the workplace. Finally, social inclusion is necessary for every citizen to maintain a balance of mental health and wellbeing. Mental health workers are in a privileged position to be part of supporting the most vulnerable in the city to fulfil their dreams of being productive members of society. The adoption of strategies discussed in this paper can help service providers and systems of care to promote service users' social inclusion. In the post-institutional era, it is time to welcome people home again.

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