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Co-producing social inclusion: the structure/agency conundrum

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Abstract

Over a decade has passed since the Labour government introduced the 1998 White Paper 'Modernising Mental Health' that made the connection between mental ill health and social exclusion. During this period the last government has placed increasing emphasis on reducing social exclusion and in the CNO Review of Mental Health Nursing, one of the 17 recommendations is to 'increase social inclusion'. This begs three important questions. First, what is social inclusion? Secondly, how do Mental Health Nurses increase social inclusion? Finally, how do you measure whether nurses have increased social inclusion? This paper will critically engage with these questions through the lens of the structure/agency debate. This refers to the degree of control that individuals have, to shape or influence political and societal factors (such as social inclusion); in contrast to a more structural account which argues that individuals are constrained or supported by social, cultural and environmental factors.

Introduction

Background

The Chief Nursing Officer's (CNO) Review of Mental Health Nursing in England (2006) outlines a vision for mental health nursing over the next ten years. To realise this vision the review makes 17 recommendations that 'aim to improve the outcomes for service users and carers'. This paper is concerned with recommendation nine, 'improving social inclusion' for people who use mental health services. Since 1997 and in stark contrast to previous administrations, the previous Labour government has put in place many policy initiatives to improve social inclusion with some notable success (see Vision and Progress: Social Inclusion and Mental Health, NSIP, 2009), although significant gaps remain particularly for the most disadvantaged groups in society (Hills and Stewart 2005). In May 2010, the Coalition Government published its *State of the nation report: poverty, worklessness and welfare dependency in the UK*. The report sets out a comprehensive assessment of poverty in the UK in 2010. The Government will use it to inform policy decisions as it advances its aims of tackling poverty and improving life chances, to ensure that everyone has the best possible chance to fulfil their potential. Social Inclusion does not get a mention. Indeed David Cameron's "mission" is not a socially included society but a "Big Society", as he himself states: "We do need a social recovery to mend the broken society and to me, that's what the Big Society is all about" (Cameron 2011). Government priorities come and go, but mental health nurses remain locked into the social inclusion agenda.

Mental health nurses are the single largest profession working with people experiencing mental health problems and although they do not work in a silo (CNO Review, 2006), they will shoulder much of the responsibility for increasing social inclusion as outlined in the CNO Review. It should be noted, however, other professions, notably Psychologists and Psychiatrists have begun to address how individual disciplines working in mental health services can contribute to increasing social inclusion. The British Psychological Society published a *Discussion Paper: Socially Inclusive Practice* (2008) in an attempt to engender a more socially inclusive society through practice and the Royal College of Psychiatrists have produced a *Position Statement, Mental Health and Social Inclusion: Making Psychiatry and Mental Health Services Fit for the 21st Century* (2009). Furthermore, one of *The Ten Shared Capabilities: A Framework for the Whole of the Mental Health Workforce* (2004) is to 'Challenge Inequality' including 'social inequality and exclusion on service users, carers and mental health services'.

The notion of increasing social inclusion for some of the most excluded and disadvantaged members of society, at first sight appears an admirable quest. Spandler (2007), however, provides a very persuasive list of reasons why social inclusion is not always viewed as a panacea (see Box 1).

Box 1

- Social inclusion is hard to define
- Social inclusion in practice implicitly assumes that the quality of mainstream society is not only desirable, but unproblematic and legitimate (Levitas 2004; Fairclough 2000).
- Social inclusion discourse implies that society is comprised of a comfortable and satisfied 'included majority' and a dissatisfied 'excluded minority'. This focuses attention on the excluded minority and fails to take seriously the difficulties, conflicts and inequalities apparent in the wider society which actually generate and sustain exclusion *and mental health problems* (Kleinman 1998; Levitas 2004; Fairclough 2000; Burden and Hamm 2000).
- *Spandler concludes:* On the one hand it offers the promise of emancipation through the resolution of social exclusion and yet it simultaneously becomes another way in which the 'mentally ill' are subject to social, moral and economic regulation.

Nonetheless, increasing social inclusion has been a key feature of UK government social policy for the past ten years; it also features in the values and principles of

good practice that will drive mental health nursing forward for the next ten years and therefore raises some important questions for mental health nurses which this paper will address. First, what is social inclusion? Second, how do mental health nurses increase social inclusion and finally how do we measure the outcome of increasing social inclusion?

These questions will be explored through the theoretical lens of the structure - agency debate. According to McAnulla (2002) the structure/agency conundrum has recently taken centre stage in how theoretical issues are addressed in the human sciences. The structure/agency debate is arguably, the fundamental question regarding the degree of control that individual agents have, to shape their own or someone other persons destiny, in contrast to a more structural account which argues that the same individuals are constrained by external factors beyond their control. Therefore, the key theoretical question raised here relates to the role that individual mental health nurses (agents) have in increasing social inclusion in the context of the political, economic, social, and cultural environment (structure).

The structure/agency conundrum

Mental healthcare professionals have an expectation to increase social inclusion (DoH 2006), however, the extent to which they alone, or as part of team, can achieve this begs an understanding and analysis of the structure and agency conundrum. Simply put the structure and agency debate centres on the extent to which an individual's choice of action is constrained or enhanced by the social structures they are located within.

Agency implies that individuals behave independently and have the capacity to create; change and influence events depending on the course of action they choose to take (Bilton *et al*, 1996; Giddens, 1984). The capacity to influence an event or intervene in a course of action is indicative of possessing a degree of power (Giddens 1984). In contrast *structure* is regarded as the social, economic, political and cultural frameworks which have been constructed and may constrain or enhance an individual to act of their own "free will". This explanation of human behaviour and action may appear too simplistic. Bilton *et al* (1996), suggest rather than polarise the structure/agency debate, we should consider them interdependently which produces a dialectical relationship '...where these two apparently contrasting elements work upon each other to produce a synthesis'. Giddens (1984) coined the phrase 'structuration theory' to make the link between

structure and agency in recognition of the duality: 'That is, structures cannot be created independently of actions while actions can never take place except within structural circumstances' (Bilton et al, 1996).

Perhaps as individuals it is easy to recognise this synthesis, at one time or another throughout our lives, we make choices and act in the knowledge that we can be both constrained or enhanced by the economic orthodoxy of the day, by the cultural norms and values of society, or by the existence of patriarchal structures which surround us. On a daily basis individual mental health nurses and mental healthcare professionals are confronted with the structure and agency conundrum when working alongside service users. Agency in this case, however, often refers to two people working together to achieve a desired outcome. The relationship between service user and provider is based on partnership and collaboration in negotiating what the service users wants to achieve. Nonetheless, the desire to independently create or change something is evidence of active agency.

As individuals, privately and publicly, we are immersed in and surrounded by different structures in our lives. Some structures such as neo-liberalism may impact more on groups such as the working class; others such as patriarchy mean that more than 50% of the population (women) are often marginalised simply as result of their gender. People with mental health problems have to function surrounded by structures, the welfare system for example, that are often detrimental to their well being and more often than not, these people lack the power and autonomy to make real and significant changes to their lives. Table 3 below outlines, although not exclusively, some of the structures which may cause people to be socially excluded who have experienced or are experiencing mental health problems. The major challenge for service users and healthcare professionals is to overcome these structures in the pursuit of increasing social inclusion.

Social Inclusion	Structure	Agency
	Neo-liberalism	
	Political institutions, rules and regulations	

Participation	Social and cultural marginalisation	Individual Service User & Mental Health Professional Power
Discrimination	Institutional and organisational discrimination	
	Cultural prejudice and stigma	
	Judicial and legislative restrictions	
Opportunity	Medical model	

Yanos et al (2000) argue that both structure and agency are important factors which impact on the recovery of people with severe mental illness. They suggest people with severe mental illness are constrained by four significant structures, obdurateness¹, ritualization² and identification/symbolization³ (Yanos et al 2000), however, recovery is possible because actions such as ‘coping’, ‘goal setting’ and ‘collective action’ by individuals can overcome these social structures. In contrast Druss et al (2009) argue that people with severe mental illness often lack the power to act as ‘effective agents and self advocates’ when trying to access the services they require. Many people with mental health problems do overcome structural constraints on the road to their recovery and often it is a testament to the sheer will of individual agency.

Mental health professionals need to recognise the many constraining (and sometimes enabling) structures in which they work. Structures such as the medical model, poverty, discrimination, stigma & prejudice and the legal system have constrained and marginalised many people with mental health problem for years. Mental healthcare professionals cannot dismantle these deeply embedded structures alone, they can however, recognise and be aware of the framework in which they practice. It is important services users are given hope and courage to

¹ Obdurateness – “institutional poverty, legal restrictions, poor housing & distressed neighbourhood”.

² Ritualization – “others routinized discriminatory practices, consumers’ risky health behaviour lifestyle & passive lifestyle”.

³ Symbolization/Identification – “incorporation of stigmatizing attitudes and identity & challenged identity through comparison and culturally dictated norms”.

facilitate their recovery; equally it is vital that as a society we build structures which enable recovery rather than hinder it.

What is social inclusion?

Social inclusion is a protean concept; there is no standard single application of a term that is used in many different countries, by a multitude of professional disciplines and in many different contexts and settings. In the United Kingdom social exclusion and mental health was first given significant prominence in the 1998 White Paper 'Modernising Mental Health' which made the connection between mental ill health and social exclusion (Evans and Repper 2000). This was taken a step further when in Spring 2003 the Social Exclusion Unit (SEU) was asked by the then Prime Minister Tony Blair, 'what could be done to reduce social inclusion among adults with mental health problems' (ODPM 2004).⁴ This report makes recommendations to embed social inclusion for people with mental health problems into the fabric of central government cutting across many departments including HM Treasury, UK legal system, Departments of Housing, Transport, Health, and Work and Pensions. Although central government takes the 'lead' on increasing social inclusion it is expected that responsibility for implementing policy and guidance is shared among many different groups and organisations including stakeholders, employers, healthcare professionals and employment services (Repper and Perkins 2009).

The institutionalisation of social inclusion is all very well, but what does it mean to frontline line mental health nurses who are expected to put the theory into practice? At a meta-level, the UK government uses the following definition of social exclusion:

Social exclusion is a short-hand term for what can happen when people or areas have a combination of problems, such as unemployment, discrimination, poor skills, low incomes, poor housing, high crime and family breakdown. These problems are linked and mutually reinforcing. Social exclusion is an extreme consequence of what happens when people do not get a fair deal throughout their lives and find themselves in difficult situations. This pattern of disadvantage can be transmitted from one generation to the next.

(Social Inclusion Task Force, Cabinet Office 2009)

⁴ The Social Exclusion Unit covers England only. Scotland ('Scottish Social Inclusion Strategy'), Wales ('Building an Inclusive Wales) and Northern Ireland (Targeting Social Need in Northern Ireland') each have separate agendas and strategies.

According to Burchardt, Le Grand and Piachaud (2002) there are generally two distinct approaches to social exclusion, which are adopted by those people who seek to operationalise the concept. First, there are those who focus on a discrete and specific problem such as long-term unemployment, street homelessness or teenage pregnancy. The second approach adopted is when the focus tends to be on a series of indicators wrapped together such as income, labour market engagement, social interaction and health. Burchardt, Le Grand and Piachaud (2002a), however, argue these approaches are too narrow and a more multidimensional approach to social inclusion is required. Thus, they offer a working definition of social inclusion which states:

An individual is socially excluded if he or she does not participate in key activities of the society in which he or she lives.
(Burchardt, Le Grand and Piachaud 2002a)

They argue the key determinate of social inclusion as outlined above revolves around participation, which they suggest has four dimensions:

1. Consumption: the capacity to purchase goods and services
2. Production: participation in economically or socially valuable activities
3. Political engagement: involvement in local or national decision-making
4. Social integration: integration with family, friends, and community

Each of these dimensions represents an outcome considered important in its own right. This is not to deny that there are interactions between the outcomes, but rather emphasize that participation in every dimension is regarded necessary for social inclusion, conversely, lack of participation in any one dimension is sufficient for social exclusion.
(Burchardt, Le Grand and Piachaud 2002a)

In the mental health arena, Bates and Seddon (2008) also emphasize the participative dimension of inclusion:

... social inclusion is not merely another term for economic inclusion in the labour market (although unemployment is a powerful factor in inclusion), but it is also about political, social and cultural participation.

Sayce (2000) adds some flesh to this definition and describes social exclusion for people experiencing mental health problems as:

... the inter-locking and mutually compounding problems of impairment, discrimination, diminished social role, lack of economic and social participation and disability. Among the factors at play are lack of status, joblessness, lack of opportunities to establish a family, small or non-existent social networks, compounding race and other discriminations, repeated rejection and consequent restriction of hope and expectation.

In the CNO Review of Mental Health Nursing (2006), the guidelines on increasing social inclusion make the connection between people experiencing mental health problems and social exclusion. In the first instance, mental health nurses are directed to the cross-governmental National Social Inclusion Programme (NSIP) which offers guidance and direction to all healthcare professions to increase social inclusion in a number of areas including employment, further and higher education, volunteering and community participation. More explicitly, the CNO Review states Mental Health Nurses can play a vital role in:

- supporting service users to retain or develop social links, supports and roles;
- providing information about, or referring service users on to, specialists schemes or to help with employment or educational opportunities;
- challenging stigma.

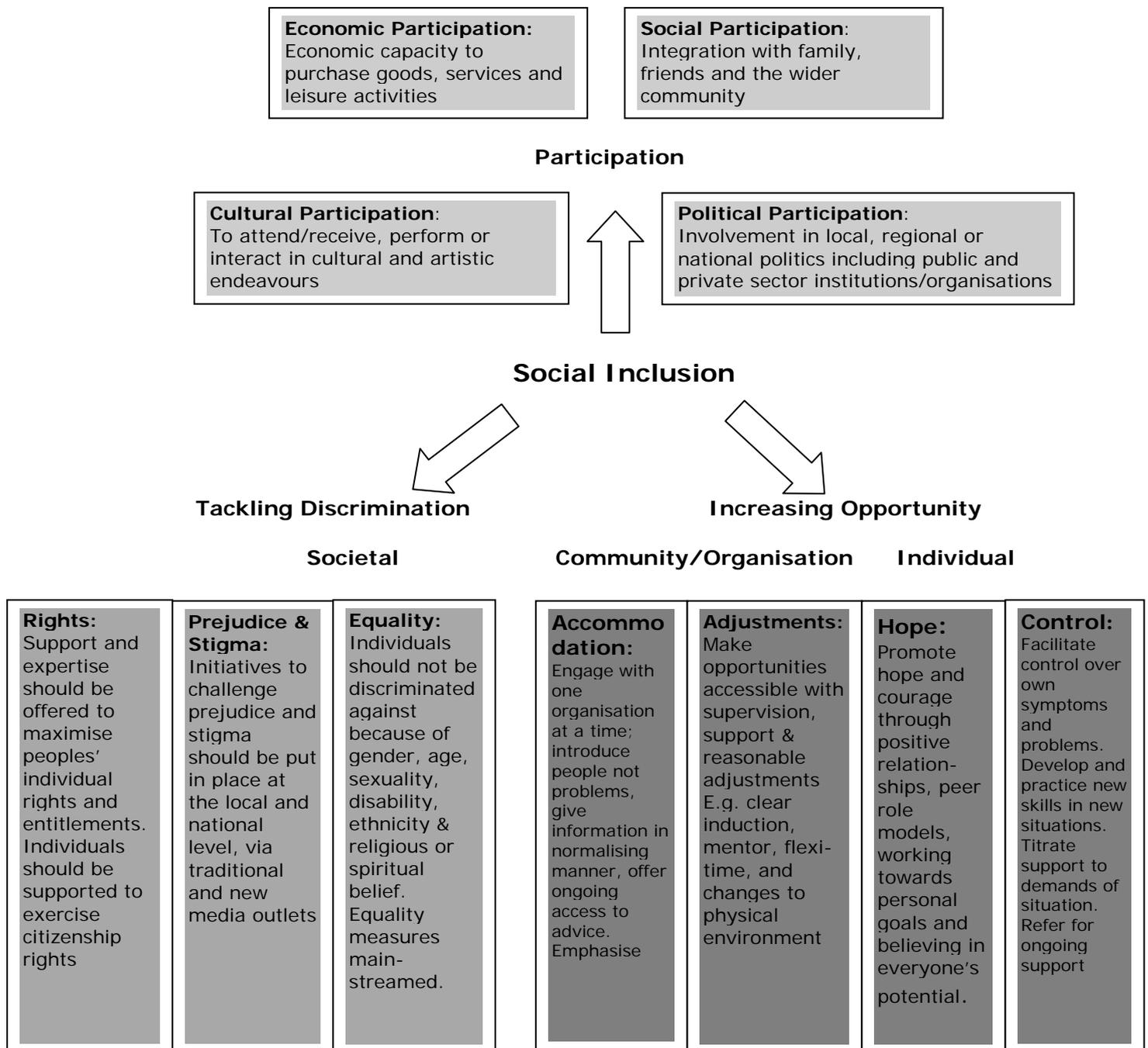
Morgan, Burns, Fitzpatrick et al (2007), conducted the most exhaustive UK literature review to date in an attempt to conceptualise a meaning and understanding of social inclusion for people experiencing mental health problems. The results of their literature review confirm that in the mental health literature social inclusion is poorly defined and therefore, difficult to measure. The definition favoured by Morgan, Burns, Fitzpatrick et al (2007) derives from Burchardt (2000) and again focuses on "participation in key social, cultural and political activities". They argue that there are four distinct advantages of this definition over others:

1. Participation can be measured and quantified in terms of frequency and duration
2. The components of participation can be mapped over time thereby capturing the dynamic nature of exclusion
3. There is the flexibility to incorporate more subjective aspects of participation such as perceived quality of social relationships arising from involvement in activities.

4. This more precise definition allows greater clarity in distinguishing direct and indirect indicators of exclusion, and risk factors. For example in this definition stigma is a risk factor for social inclusion in that can be a barrier to participation.

We agree that participation is crucial to increasing social inclusion for people experiencing mental health problems and we accept that the term 'social inclusion' needs further conceptual clarity to guide interventions that might increase the inclusion of people with mental health problems. This definition however, remains incomplete since there is no mention of economic participation, nor does the definition acknowledge the discrimination faced by many people with mental health problems and the impact that this has on opportunities available to them. Therefore, rather than offer a precise definition of social inclusion we propose a Social Inclusion Framework (see Figure 1 below) which has three broad dimensions – participation, tackling discrimination and increasing opportunity - all of which need to be considered by nurses and other healthcare professionals when attempting to increase social inclusion.

Figure 1: **The Social Inclusion Framework**



One of the main selection criteria for the definition proposed by Morgan, Burns, Fitzpatrick et al (2007) is that it is measurable (this paper will consider how we measure outcomes below), however, we suggest the framework for social inclusion must be much broader and contain elements which might be more difficult to quantify.

How do Mental Health Nurses increase social inclusion?

Increasing social inclusion is the responsibility for all mental healthcare professionals, but how do we do it? The social inclusion framework discussed above outlines some of the requirements for increasing social inclusion, however, these aspects of social inclusion rest on the conjecture that service users want to be socially included into the mainstream, ironically a mainstream that is arguably structured in a socially exclusive manner. There is often an assumption from policymakers and healthcare professionals that the route to social inclusion is via the job market, competitive or otherwise, but this assumption needs to be radically challenged.

Employment is not the only Fruit

There are many and varied benefits to employment, but for many people experiencing mental health problems the workplace can be a place of anxiety, stress and discrimination and reinforce the exclusionary factors that are supposed to be reduced. Also, the unpredictability of the job market can give cause for much concern. In September 2007 there were 1.64 million people unemployed in comparison to September 2009 when 2.46 million people were unemployed (Office for National Statistics 2009). This makes the job market highly competitive, therefore, is it expected that people experiencing mental health problems are operating on a level-playing field in this market?

In a systematic review of the literature Crowther, Marshall & Bond et al (2001) looked at the best way of helping people with severe mental illness obtain competitive employment.⁵ Eleven randomised controlled trials were selected and they concluded that supported employment⁶ is more effective than prevocational training⁷ at helping people with severe mental illness obtain competitive employment. The interesting aspect of these findings stems from the fact that when the review was completed, in the UK context, prevocational training was regarded as the "norm", however, there were a number of supported employment agencies around at the time.

Supported employment is only one model of getting people experiencing mental health problems into work among many others including "Social Firms/co-

⁵ Competitive employment - a paid job at the market rate and for which anyone can apply.

⁶ Supported employment places service users in competitive jobs without extended preparation and provides on the job support from trained "job coaches" or employment specialists.

⁷ Prevocational training assumes that people with severe mental illness require a period of preparation before entering into competitive employment.

operatives," "Local Exchange Trading systems," and "Club Houses" however, as Evans and Repper (2000) point out:

Unfortunately, there is a definite lack of UK research and outcome data available to evaluate the effectiveness of these initiatives. Not only is there a dearth of data about individual models; there is also a lack of research comparing the relative benefits of different type of work initiatives and financial benefits and costs of all types of work projects.

Huxley and Thronicroft (2003) suggest that Psychiatrists can reduce the economic burden of social exclusion by preventing people who have developed a mental health problem from losing their jobs by using the concept of 'reasonable adjustment.' This means the profession could support employers to make reasonable adjustments – such as offering flexible work patterns – to enable a person to remain in work rather than take sick leave when experiencing problems. Sayce (2000) agrees and suggests, 'Psychiatrists, and other mental health professionals can build 'social inclusion' into clinical practice, by including in care plans users' aspirations for work, education, relationships and other chosen journeys of 'recovery'".

Irrespective of which model is adopted, the benefit of any employment initiatives must correspond to the needs and requirements of each individual service user. Employment is only one component part of the social inclusion framework and should not be rendered any more important, than say, political participation just because it happens to fit in with a government's political agenda of getting people off disability benefits or employment benefits to save money rather to promote employment and well-being. What about increasing social inclusion by offering 'hope' to people experiencing mental health problems? Arguably, promoting hope and courage in a supportive positive relationship should be the starting point of any therapeutic relationship? Mental healthcare professionals need the skills and training to work in partnership with people experiencing mental health problems to increase social inclusion, central to this process is a fundamental understanding of what individual people want.

Future Directions: Direct Payments?

Since 1st April 2009 individual service users have been given the right to access a personal health budget, and although this is a fairly recent initiative, there is a growing belief that "direct payments" will contribute to the social inclusion agenda, since according to Lord Darzi (High Quality Care For All 2009):

Personal health budgets are part of a broader picture of personalisation and empowerment, including self care and self-management, choice, care planning, and capturing and responding to patient voice.

These sentiments very much echo the social inclusion agenda, but only time will tell if giving service users the capacity to control their own individual budgets will procure the desired effect of increasing social inclusion?

Inclusion Frameworks

The 10 Essential Shared Capabilities (ESCs 2004), which identifies the common set of 'purposes and practices' that practitioners, service users and carers have in the delivery of mental healthcare services. Following this in 2007, CSIP (Care Services Improvement Scheme) produced the best practice document 'Capabilities for inclusive practice' for all core mental health professional 'to develop a set of capabilities, capturing best practice in order to drive the transformation of services and promote socially inclusive outcomes' (DH 2007). The resultant social inclusion framework which is based on The 10 Essential Shared Capabilities, offers guidance, advice and lists the distinctive skills that are required by individuals and organisations to deliver on social inclusion outcomes. The capability framework focuses on the following 10 domains:

1. Working in partnership
2. Respecting diversity
3. Practicing ethically
4. Challenging inequality
5. Promoting recovery
6. Identifying people's needs and strengths
7. Providing service user centred care
8. Making a difference
9. Promoting safety and positive risk taking
10. Personal development and learning

Bates and Seddon (2008) in similar vein offer a comprehensive inclusion plan for healthcare professionals who require additional tools in increasing social inclusion. The *Social Inclusion Planner* (Bates and Seddon 2006) is based on over 100 interventions, grouped into seven primary categories, which make up the full plan. The seven stages of the social inclusion plan are:

1. Getting to know the person
2. Getting to know the community
3. Building a capacity in mental health services

4. Building capacity in community organisations
5. Support for the whole of life
6. Getting there and settling in
7. Sustaining participation

The Capability Framework and the Social Inclusion Planner are similar in that they both focus on the global needs and requirements of the service user, but more importantly these frameworks provide an opportunity to individualise and tailor care and support for each unique person. These frameworks together with the social inclusion framework outlined above, at the very least, provide nurses and healthcare professional to work in tandem with service users to begin the journey towards social inclusion and ultimately recovery. Beginning the journey is one thing, but how do we know if we have arrived?

Measuring Social Inclusion?

The measurement of social inclusion is a relatively recent phenomenon; however, the starting point of any measurement tool or indicator should be with the service user or person experiencing mental health problems. How often do mental health care professionals ask service users, if they, as a result of using a mental health services do they feel more socially included? There are many service user satisfaction questionnaires (such as The National Patient Survey Programme), but these indicators refer to the degree of satisfaction people have with mental health services as a whole, rather than measuring individual well being outcomes.

Outcome Indicators

The National Social Inclusion Programme produced an 'Outcomes Framework for Mental Health Services' (2009) which is offered as a resource for service providers (and commissioners) who seek to increase social inclusion as part of the support, care and treatment they provide. The framework is structured around the following eight different categories 'to reflect the different life domains and functions of mental health services' (NSIP 2009):

1. Community Participation
2. Social networks
3. Employment
4. Education and Training
5. Physical Health

6. Mental Wellbeing
7. Independent Living
8. Personalisation & Choice

Box 1

Social Networks	
Intended Outcomes <ul style="list-style-type: none"> • Increase the size and range of social networks for people with mental health problems • Increase number of people with mental health problems maintain social and caring roles 	Key Outcome Indicators
	Number of people supported to develop positive new relationships/friendships
	Number of people supported to strengthen existing relationships with family or friends
	Additional Outcome Indicators
	Number of people enabled to begin giving support to others
	Number of people supported to begin accessing peer support or self-help groups
	Number of people supported to access appropriate family interventions
Number of people supported to maintain parenting and caring roles through a crisis period	

Source: NSIP 2009

Box 1 above is an example from one of the identified categories 'Social Networks.' Within each category there are, intentionally, only two specific 'Intended Outcomes,' and a small number of 'Key Outcome' Indicators' and 'Additional Outcome Indicators' since it was considered the selected indicators outcomes would lend themselves to evidencing progress. To be fair the outcomes or indicators are not set in stone and outcomes should be tailored to meet the needs and requirements of individual service users. To measure if the outcomes have been met it is suggested services can count if service users are achieving each outcome indicator, or they can discuss the categories and indicators with the people who using the service as part of the support planning process.

The Inclusion Web

Hacking and Bates (2008) have devised 'The Inclusion Web' which is a collaborative measurement tool (which provides feedback also), between service

user and practitioners and is a strategy which records changes in peoples social networks (people) and environments (places). The people and places scales are drawn from eight life domains (Arts & Culture, Education, Employment, Faith & Meaning, Family & Neighbourhood, Physical Activity, Services and Volunteering) which represent the domains of social network and community where any intervention should take place. The desired aim for a positive outcome, for people experiencing mental health problems, is to generate an increase in the number of people and places (the overall measure is called the clockspread) in each life domain on the Inclusion Web. Hacking and Bates (2008) conducted a pilot study to test if service users who received an enhanced service against this who received standard care improved to see if there was an increase in the mean scores for people and places and correspondingly in the total clockspread measure.

If mental nurses and other healthcare professionals are offering packages of care or individual interventions with the aim of increasing social inclusion, it is important they measure the success of their outcomes. Outcome indicators (NSIP 2009) and measuring tools (Hacking and Bates 2008) are recent innovations which, at the very least, provide healthcare professionals with a framework for measuring outcomes of social inclusion. The social inclusion agenda has made great strides in the past 10 years; the challenge for nurses and the other mental healthcare professionals in the next ten years is to provide the hard evidence that service users are no longer excluded from mainstream society.

This is no mean feat. The next four years the government of the day will have to tackle a budget deficit of £178 billion pounds which will witness widespread cuts in public spending (BBC, 2010). The NHS will not be immune from these cuts and its possible many long standing mental health services may disappear or be reconfigured in the name of efficiency savings. These structural readjustments will present problems for individual healthcare professionals providing support, care and treatment to mental health service users.

Discussion

Social inclusion is not well defined and even when it is there is a divergence of opinion of what exactly it means. Complicating this further is the notion that increasing social inclusion might not be desirable or in the best interests of mental health service users. Nevertheless there is an expectation that mental

health nurses, and others, should seek to increase the social inclusion of the service users they support and care for on a daily basis. Despite the reservations that social inclusion is not always desirable or achievable we propose a social inclusion framework based on increasing opportunity, tackling opportunity and facilitating participation in the widest sense.