Response to the Office of the Deputy Prime Minister's Social Exclusion Unit consultation on mental health

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How does mental ill health cause and sustain social exclusion?
Mental ill health leads to a decline in all aspects of functioning. It also tends to lead to a reduction in social contact of all types and of socially supportive networks in particular. Mental ill health can lead to difficulty complying with prescriptive social expectations, and important aspects of society - such as employment and education - are still often set up to a “one size fits all” model of participation. Where adjustments are made they tend to happen on a reactive individual basis. Given the high levels of stigma attached to mental health this is problematic because people with mental health difficulties are often reluctant to declare their difficulties and, when they do, the level of ignorance which abounds often means that they do not encounter a sympathetic response.

None of the main ideas or systems relating to mental health are geared up towards preventing people from becoming socially excluded. The medical model works by treating and caring for people who are already very ill and have become socially excluded. The disability legislation is also flawed in that it requires people to have had a “clinically recognised condition” for a year or more. This imposes an extra hurdle for people with mental health difficulties since the requirement that a condition is “clinically well recognised” applies to no other disability and is inappropriate because of the complexity of diagnosing mental health difficulties. It also means that the only people with mental health difficulties who can claim any protection against social exclusion are those who may already have been excluded from education or employment.

What are the 3 most important problems you would like to see the Social Exclusion Unit project address in relation to mental health and social exclusion?
Given the importance which is attached for society in general to the issue of education, this ought to also be given high priority for people with mental health difficulties. This has to be across all educational opportunities and not just confined to basic skills. The government aims to give 50% of young people an experience of Higher Education. It is important that what is seen as contributing a great deal to young people in general is also seen as of great significance to those with mental health difficulties.

Services and approaches need to be drastically re-oriented to being about prevention and early intervention. Early intervention in this context has to include intervention with those susceptible to developing serious and/or enduring mental health difficulties, rather than as is often the case, being solely concerned with intervening early where people experience relapses. Approaches need to be based on preventing social exclusion in the first place, rather than being solely about trying to promote social inclusion for people who are already marginalised. People with mental health difficulties who become socially excluded lose key skills and also have gaps in their career histories which are likely to be off-putting to potential educators and employers. They are also then faced with the uphill task of proving to someone that they can cope with demands that would be placed on them, when they have no recent evidence to back up such a claim.

There needs to be a more sophisticated model for understanding the needs of people with mental health difficulties. They are not served well by an assumption that a generic disability model will lead to their needs being addressed. This is demonstrated by the fact that the levels of socially meaningful activity have hardly increased whilst the levels of participation of people with other disabilities has increased dramatically.

There is also a complete dislocation between the “disability” models which are used by disability organisations and in the Disability Discrimination Act (DDA) and the care and treatment models which are used in clinical settings. Current “disability” models often do not reflect the reality of the experience of people with mental health difficulties. Mental health professionals need to see part of their remit as being about promoting the rights of people with mental health difficulties rather than being purely about treating an illness. Mental health professionals in general have little knowledge of the DDA and see little connection between this piece of legislation and their work.

Do you think people with mental health problems want, and feel able, to work? Why/Why not?

Some people with mental health difficulties do not feel able to work at any time, some will feel able to work most or all of the time. There is a far larger group who will feel able to work some of the time, but the level and intensity of the work they are able to undertake will vary.

In considering this question it should be appreciated that the majority of people who experience mental health difficulties do recover from them either permanently or are symptom-free for prolonged periods. It is therefore important to not determine policy purely by looking at people with mental health difficulties as a fixed group with static abilities and needs. It is important that people do not drop out of employment as soon as mental health difficulties develop – there is nothing in law at present which would prevent a person being dismissed from their employment as soon as they developed a mental health difficulty.

People with mental health difficulties face enormous structural difficulties in terms of securing and holding down employment and the risks associated with seeking employment such as loss of benefits and loss of support and security can be overwhelming.

People with mental health difficulties often do not feel that they can pursue employment because they will be unable to cope with the demands of the work place. With other disabilities there is emphasis placed on adjustments being made to workplaces to accommodate people’s needs, but this is simply not the case when it comes to mental health difficulties.

Problems such as lack of confidence or low self-esteem are compounded by issues such as motivation and sleep problems which can be discouraging because, when at their worst, they are likely to mean the person feels unable to meet the inflexible demands of most modern work places.

The clinical emphasis on mental health services is on controlling mental health conditions through medication. The medication which people take often leads to significant side-effects which have an effect on the chances of people undertaking employment. The fact, for example, that medication may affect concentration would not usually be seen as a major consideration. This is indicative of a culture of low expectations for people with mental health difficulties, the underlying assumption being that the best which can be hoped for is some short-term relief of symptoms rather than a concerted attempt to promote social inclusion.

What are the main barriers to employment for adults with mental health problems?

People with mental health difficulties have often experienced periods of time out of the labour market and may have difficulty convincing a potential employer that they have the relevant knowledge and skills.

The labour market is very inflexible in terms of what it expects from people participating in it. Casual work is inherently stressful given that it will often involve working in several different places and is less likely to lead to an employee becoming an embedded, respected, and well-supported member of a team. Part-time work is usually offered as half a full- time equivalent, so there is little scope for people with mental health difficulties to attempt employment which suits the amount of hours they feel able to work. Given that employers are usually looking to recruit employees who will work a certain number of hours, this may disadvantage people who can't demonstrate having recently worked those number of hours and indeed are likely to have had a history of difficulty in maintaining regular employment.

Crucially, however, the labour market does not cater for the fact that mental health difficulties are variable in their intensity and therefore have variable consequential impact on employment. A person with a mental health difficulty may, for example, be perfectly capable of performing a full-time job for 30 weeks of a year, a half-time contract for another 5 weeks and then be only able to manage a day-a-week for the rest of the year.

Re-enforcing this difficulty is the fact that the benefits system is not flexible either. Incapacity benefit is awarded on the basis that someone is deemed unfit to work and operates on the assumption that for this to be the case the difficulty must be long-term and enduring in nature; this does not take account of the episodic nature of mental health difficulties and presents people with mental health difficulties with an all-or-nothing situation – either they are able to cope with all the demands of the labour market at all times, or they are not able to cope with any of the demands at any time.

Another important barrier is the huge level of stigma still attached to mental health difficulties. This re-enforces the low levels of confidence that people with mental health difficulties often have. They will often feel that no employer would want to take them on and fear that they will receive a very negative reaction in the work place. Coupled to this is the fact that people with mental

health difficulties are often very afraid of taking on challenges which could lead to them feeling that they have failed in some way.

Employers and other employees for their part are more likely to be prejudiced about mental health difficulties than about other differences amongst employees. Pejorative words associated with mental health are routinely used in most work places which, if associated with other disabilities, race or gender, would be seen by most people as highly offensive.

Where goodwill exists to assist people with mental health difficulties into employment, people often lack confidence in believing that they have the necessary skills to facilitate it happening. They are also likely to drastically overestimate the impact that someone with a mental health difficulty would have on the working environment, and also either drastically overestimate or drastically underestimate the adjustments which would need to be made.

What is the typical experience of adults in work who have mental health problems?

A huge number of people with either diagnosed or undiagnosed mental health difficulties are in employment and so there isn't really a "typical" experience and some people will have very negative experiences and some very positive ones.

A common experience for people in employment is the dilemma of whether to declare their condition to their employer. If they do so they fear a prejudiced response which, except under the narrow criteria set down in the DDA, would often be perfectly legal. If they do not disclose they are, however, faced with the prospect that they could be dismissed for not having done so if their mental health difficulties ever become apparent.

People with mental health difficulties often experience difficulties in areas such as motivation, time-keeping and concentration and, because of poor sleep patterns, may often be very tired during the day. As people often don't understand the difficulties they are experiencing they can often be incorrectly perceived by colleagues and managers as lazy, disinterested or weak, as well as being perceived as having far less ability than they often do. This can therefore lead to them becoming marginalised within the workplace and only offered tedious and undemanding tasks to do. This is likely to compound the negative self-perception that they will often have and can lead to an ever decreasing spiral of productivity.

People in the work place may be sympathetic to their difficulties, but in some cases would liken the experiences of someone with severe depression to their own experiences, or those of people they have known, of having felt low. This can lead to their real issues never being recognised and their needs being unmet, in a misguided attempt to "treat everyone the same."

Alternatively some people - in an attempt at being sympathetic - can lower their expectations inappropriately. This is both patronising and gives the employee no chances to progress, whilst re-enforcing the idea that they are

not and never could be a valued employee (which people with mental health difficulties will often believe of themselves in any case).

Hostility and prejudice are likely to be experienced by people with mental health difficulties in the workplace, and in many cases they will experience other employees being frightened of them. This is not helped by the government concentrating its legislative efforts on the tiny minority of people with mental health difficulties who are violent.

How often do you think adults in work lose their jobs following the onset or relapse of mental health problems, and for what reasons?
Again there would be a variety of experiences, a vast number of people with mental health difficulties can and do hold down jobs; 1/4 of the population have a mental health difficulty in any given year!

For those who do hold down jobs, their mental health difficulties are often hidden because the majority of people with mental health difficulties will not declare this to their employer for fear of discrimination. This in itself means that when employers do become aware of mental health difficulties it is usually in response to people experiencing difficulties in performing their duties. This means employers are likely to have an unrealistically negative view of people with mental health difficulties as their positive contributions may not be recognised.

The fact that people with mental health difficulties will tend to try to hide this from employers leads in itself to a level of stress, since they live in fear that if their mental health difficulties are discovered they will lose their job for not declaring their difficulties. In this way people with mental health difficulties often feel in a lose-lose situation with regard to the issue of disclosing their difficulties. This does, however, lead to little opportunity for responsible employers to offer appropriate support to employees with mental health difficulties, or to develop preventative strategies based on the real experiences of people with mental health difficulties.

People with mental health difficulties will tend to find it more difficult to hold down jobs where they have little or no control over how they organise their working day. Jobs in which people are able to organise and plan their work in way which fits with their own capabilities and variations in their mental health are likely to be easier for people with mental health difficulties to hold down. Such jobs are also likely to be easier for people with mental health difficulties because they are more likely to offer a level of job satisfaction and consequent boost to self-esteem. They are therefore more likely to have a positive effect on mental health than other jobs in which people feel little control over their working day, which is recognised to increase stress levels. Such jobs tend to correlate with higher skill levels and higher levels of education.

As mental health remains largely a taboo in the work place one of the major factors contributing to difficulties in remaining in employment is that when employees first develop mental health difficulties they often do so without any

support relevant to their employment. This is reflected in the fact that whilst stress is the number one cause of lost working days in the UK, physical hazards remain the main concern of employers and Health and Safety professionals. The concern for employee welfare has not kept pace with the changes which have taken place in the job market which have moved most employment out of heavy industry and into the service sector.

What is the best way to help adults with mental health problems find and keep work? Please give details of any examples of good practice or promising approaches.

People with mental health difficulties need to be seen as valued employees and employers need to be proud to declare their positive employment practices in this area, as they might be, for example, with regard to people with physical disabilities. Employers need to be encouraged to confront the realities of mental health and employment rather than the subject being hidden under a generic disability banner and treated as if it were something affecting a tiny minority.

Many employers now are happy to claim to be "positive about disability", promising to offer interviews to people with mental health difficulties who meet employment criteria; it would be a huge step forward if employers felt able to make such statements explicitly about people with mental health difficulties. It also has to be recognised however that many of the things which might traditionally be seen by employers as being things they looked for in an employee might be difficult for someone with a mental health difficulty to demonstrate, such as punctuality, uninterrupted work records and few days off sick.

Traditional ways of recruiting people often lead to a situation where what stands out when people with mental health difficulties apply for jobs are perceived deficits. Models need to be developed to enable people with mental health difficulties to demonstrate the positive attributes which they can offer to an employer, such that employers see making adjustments as making good business sense rather than perceiving them as a difficulty or a financial drain.

There needs to be greater flexibility in working arrangements. Some people with mental health difficulties will be able to cope with a full-time job for much of the year but have periods where that is not the case. There is rarely any flexibility within the labour market to increase or decrease working hours in response to personal needs, where such flexibility does exist it tends to be based on the assumption that any changes affecting the individual are of a permanent and unchanging nature and that therefore the same should be true of any adjustments; this rarely reflects the reality for people who experience mental health difficulties.

Where people with mental health difficulties do gain employment this will often be seen as a great success and be likely be taken as an indication of improved health. This therefore may correspond with a decrease in the level of support offered to people just at a time when they are experiencing an increased level of stress. The sort of services which are traditionally provided

to people with mental health difficulties take little account of what people's actual needs might be at such times. Whilst it is true that they may have less need for many aspects of support for their mental health, they face a huge number of extra pressures:

They may be working much longer hours in many cases than they have been used to – leading to extreme tiredness. At the same time they may be dislocated from networks that they had found socially supportive, for example by previous attendance at a day centre. If they were living in any form of supported housing they will probably have had to leave it because no funds will exist to allow them to continue to stay in this environment.

They will also be faced with having to undertake more practical tasks such as ironing clothes for work. They will be likely to have to undertake their shopping when they are more tired than would have previously been the case and at busier times such as the weekend, which is inherently more stressful. Support with these extra pressures should be given emphasis during a transitional phase into employment and gradually reduced as the person becomes more used to the demands of regular employment.

How much emphasis do local services place on helping people with mental health problems find and keep work?

Local services place little emphasis on this. There is an unhealthy dislocation between considerations of care and treatment and broader consideration related to social inclusion. Care plans are driven by a medical model which emphasises management of mental health conditions, primarily through medication. Where care plans have a broader perspective it still tends to be the case that issues related to social inclusion are seen through a care and treatment prism. i.e. the primary consideration being the effect that any efforts might have on the mental health condition. It is very rarely the case that care and treatment are considered through a social inclusion perspective. i.e. the primary purpose of care and treatment being to enable the individual to lead a meaningful life in which they are included within mainstream society. This is reflected in the prescription of medication where side-effects on, for example, sleep and concentration are perhaps not given the prominence they would be if employability were seen as a main aim of mental health services.

Where efforts are made with regard to employment there is an undue emphasis on provision of low-level employment or alternatives to mainstream employment. This is aimed at providing a service to people who, for the most part, have been long-term users of mental health services and have already been excluded from mainstream society for prolonged periods.

There is also too much emphasis on people undertaking voluntary or community related work. Whilst this may in itself be laudable, it is only of relevance to an employment strategy if it relates to an area in which the individual is interested in undertaking employment and if it allows the person to either acquire or demonstrate skills which will be seen as desirable by a potential employer. Caution also needs to be employed so that such projects are not in fact used solely as an alternative to mainstream employment.

Where mental health services engage with issues of social exclusion the tendency is to focus on ameliorating the worst excesses of social exclusion rather than being about promoting genuine social inclusion and, more importantly, preventing the creation of social exclusion in the first place.

How does the welfare benefits system, including the operation of housing benefit, affect people with mental health problems who want to resume work?

This question is partly answered in answers to other questions. The benefit system creates a catch-22 for people with mental health difficulties. In order to claim benefits such as incapacity benefit they have to convince people that they are unfit to work. In order to try and secure employment they have to convince an employer of the opposite.

In both cases the person with a mental health difficulty is for the most part trying to convince someone of something which is only partially true. The reason that these things are only partially true is because of the rigidity of both the benefits system and the labour market. In both cases, the assumption that people with mental health difficulties will see some major improvement in their circumstances by generic approaches to the issues of disability is constantly proved erroneous.

The fact that a person taking up employment stands to lose all their benefits and then, if they dropped out of employment might have a period of time when they were deemed not to qualify, is a huge disincentive to seeking employment. What it means is that at a time when a person is undertaking the most profound changes in their life and are therefore likely to be at their most vulnerable, any form of safety net is removed.

What could the government do differently to enable more people with mental health problems to work?

Modifications to the Disability Discrimination Act as suggested by the Disability Rights Commission and MIND would be helpful. The DDA only offers protection to people who have long-standing mental health difficulties, who are often in any case already excluded from employment. It therefore does nothing to prevent social exclusion from occurring in the first place.

The need for a condition to be clinically well-recognised ignores the fact that mental health professionals have been attempting to get away from prematurely labelling people as having a specific mental health difficulty. It also ignores the fact that research has consistently shown that accurate diagnosis can in many cases take several years. It is, in the final analysis, discriminatory since this requirement is not placed on other disabilities.

The benefits system needs to be changed to enable people with mental health difficulties to work as much as they are able rather than either full-time or not at all. This also needs to be responsive to fluctuations in mental health in order to make it practical for employers to be more flexible with regard to the patterns that they expect people with mental health difficulties to work.

The important links between health and education need to be emphasised. Education is important to help the UK become a highly skilled economy in anticipation of the idea of it becoming an increasingly knowledge-led economy. This emphasis is completely lacking when it comes to people with mental health difficulties. The Department for Education and Skills (DfES) should be seen as a lead agency with regards to mental health, and in particular in promoting the employability of people with mental health difficulties.

Whilst the government aims at 50% participation in Higher Education (HE) amongst young people and emphasises widening participation in HE, the issue of mental health, which would be likely to be central to success in both these areas has remained largely invisible.

Which community-based services, civic and recreational activities are the most important to people with mental health problems? Please give details of any examples of good practice.
The same range of opportunities and services which are important to people in general are important to people with mental health difficulties. They have as broad a range of interests, skills and abilities as the population as a whole and it is a mistake to treat them as being a homogenous group. Social inclusion has to be across the board; social inclusion can not be achieved in selected areas without progress being made in society as a whole.

As with society in general however there are certain areas which might be seen as being of paramount importance; these should be the same areas as for the population as a whole, and currently that is not the case. The emphasis which has been placed on Higher Education for young people should have led to some natural congruence between the aims of the National Service Framework for Mental Health (such as suicide prevention, early intervention in psychosis, and mental health promotion) and the aim of widening participation in education.

The DfES does not appear to have a strategy with regard to mental health in Higher Education and this is reflected across the sector as a whole. Higher Education has the potential to have an extremely positive effect on young people's self esteem and life-time opportunities and this should be every bit as true for people with mental health difficulties (or those vulnerable to developing them) as it is for everyone else. Higher Education can be structured in a way which builds confidence and counteracts some of the disabling effects of mental health difficulties; it is at present sometimes structured in ways which exclude people with mental health unnecessarily from full participation.

The Progression Support Team at Nottingham Trent University which supports students with established mental health difficulties and those who face barriers to academic progress (and therefore may be viewed as vulnerable to developing mental health difficulties) has been successful in supporting a wide range of students to succeed who would otherwise have

been likely to drop out of education and/or become far more severely disabled by their mental health difficulties.

The UMHAN (University Mental Health Advisors Network) is an organisation working to influence the development of positive approaches to mental health and Higher Education. It is interested in working alongside key partners such as the DfES, National Institute for Mental Health in England, and the Social Exclusion Unit to bring this about.

How easy is it for people with mental health problems to access these services? Why/Why not?

It is not at all easy for people to access such services. Funding for these services comes through the Disabled Student Allowance (DSA) but the way in which this is administered by some Local Education Authorities is deeply discriminatory against people with mental health difficulties. The result being that whilst mental health difficulties are the biggest cause of disability amongst young people, the number of students with mental health difficulties being awarded the DSA is tiny. Where DSA is awarded it is not always clear that what is being funded has any direct relevance to the person's difficulties.

The fact that DSA is awarded on the criteria of "disability" (which seems to be determined largely with reference to the length of time since diagnosis) does not reflect what is needed in order to support the progression of students with mental health difficulties in Higher Education. Even within this concept there are vast discrepancies and inequities between different LEA's as to their interpretation of entitlement.

The fact that funding is directed solely towards those with "disabilities" means there is little prospect of using support in a preventative way to prevent social exclusion occurring. It has some limited value in its current form in assisting those students who have already experienced social exclusion. Since in many cases these will be students who have experienced several years of under performing in Higher Education, this is clearly not cost effective. It would also, strictly speaking, exclude students who had experienced, say, a suspected psychotic episode but were nevertheless clearly in need of additional support to prevent them dropping out of education.

The DfES does not at present appear to have a strategy to ensure equality of access for students with mental health difficulties to Higher Education or to funds designed to support the progress of students with mental health difficulties.

The issue of mental health in Higher Education has been largely sidelined and massively misinterpreted as being relevant to a very small subset of students. The rights and needs of people with mental health difficulties in trying to pursue Higher Education appear to have been seen as largely peripheral to the aims and objectives of mental health providers, disability organisations and education-related organisations. The reality is that it should be a central concern of all of these agencies, especially those which are in effect arms of the government or receive significant amounts of funding from it.

The idea of independent study within Higher Education can also be problematical for students with mental health difficulties. There is sometimes a lack of clarity about what exactly Higher Education is designed to achieve, which leads to difficulties in understanding what the expectations should be of someone with a mental health difficulty who wishes to study, and of considering adjustments which might be made in order to support them.

How could access to services, civic and recreational activities be improved for people with mental health problems? Please give details of any examples of good practice.

Student loans and other funding made available to the student body do not reflect the fact that students with mental health difficulties may need to come in and out of education and may be able to work at different paces at different times through their academic career. When DSA is awarded to students with mental health difficulties it often ends out of term-time, even when students as a result of their mental health difficulties have work which they need to complete. It also ceases when they would normally have been expected to have completed their course which means that students who have not been able to complete all their work as a result of their mental health difficulties will automatically be excluded from the support which would help them to complete their course. Adjusting these systems in ways which meant they didn't operate in a discriminatory way against students with mental health difficulties would be very helpful.

There is also a need for a fundamental rethink about the funding for specific support for students with mental health difficulties in Higher Education and the ways in which they are able to access this. This needs to be more than an administrative review of the DSA; it needs to be linked to developing a clear strategy in supporting students with mental health difficulties to succeed in HE and then to design funding mechanisms that support this. The current review of the DSA has consulted widely with people with knowledge of physical disabilities and runs the risk of replicating the difficulties with the existing system which effectively exclude most people with mental health difficulties from accessing support.

Access to the DSA or any replacement form of funding for support needs of students with mental health difficulties should be benchmarked against levels of access to benefits, such as incapacity benefit. A mark of progress towards social inclusion might be that more people with mental health difficulties were accessing the DSA than were accessing incapacity benefit. There should be a drive to encourage the uptake of the DSA by students with mental health difficulties accompanied by a fundamental overhaul of the ways in which they are able to access it. The practice of Nottingham City and Nottinghamshire County Council have had a significant impact in assisting students from these areas to access appropriate support.

How important are families and friends in supporting people with mental health problems?

Social connections are generally very important and can have a significant impact on improving mental health. It is important though to recognise that such connections can also have a profoundly negative effect on mental health and that a history of deprivation or abuse are significant factors for some people in developing mental health difficulties.

In looking at questions such as this it is important not to treat people with mental health problems as a single homogenous group. The significance and the particular composition of relationships will differ widely from individual to individual.

Whilst more could and should be done to support relatives and friends, this needs to be done in a sophisticated way. People with mental health problems need to be respected as being independent people who are, as far as possible, in control of their own lives. It is important that attempts to include and support significant others do not lead to people being infantilised or given undue influence over the lives of other adults.

What kinds of attitudes exist in local communities towards adults with mental health problems? Please give details of any examples of good practice in building positive attitudes.
There are a range of attitudes towards mental health difficulties within communities. People do not tend to wish to live near people with mental health difficulties. (Though in reality most people do live near residential homes for people with mental health difficulties and are ignorant of the fact).

There is often little differentiation made between people with mental health difficulties and people with learning disabilities. People with mental health difficulties are often wrongly believed to be unintelligent. There can be a patronising response which assumes people with mental health difficulties should be pitied and are incapable. With any given stereotype relating to mental health there are often other strong contradictory stereotypes; so for example people with mental health difficulties are also often seen as “mad genius” types.

Possibly the main reason that people with mental health difficulties are not welcomed into communities is because they are seen as dangerous and/or sexually predatory. This is based on the misguided notion that levels of violence by people with mental health difficulties have been rising, when in fact the reverse is true. This prejudice is fuelled by an almost routinely negative portrayal of mental health issues in all forms of media. Large organisations and firms which would make great efforts to not be seen as prejudiced in other ways apparently do not recognise this as an issue for their advertising when it comes to mental health.

This negative view is compounded by the only actual and proposed mental health legislation this century being about control and placing a heavy and undue emphasis on consideration such as dangerousness.

Legislation and sanctions are required which ensure the media is accountable for their portrayal of mental health and that requires the portrayal to be balanced and fair as, for example, is required by public service broadcasters on political issues.

How well co-ordinated are services which support people with mental health problems? Are lines of accountability clear?
There is a narrow vision of what services should be accountable for. They are mostly concerned with the care and treatment of chronic mental health conditions and do not currently place a great deal of emphasis on promoting social inclusion. Links with external agencies and with the community in general are poor, and indeed approaches from the wider community are often received defensively.

Psychiatrists are often given an undue influence over what mental health services offer to people and as such distort care plans towards unduly medicalised models of intervention. Managing mental health conditions through medication takes centre stage and all other considerations tend to be seen as peripheral importance.

For a student in Higher Education, for example, being supported in a way which enables them to complete their course is every bit as significant to their long term prospects but this is unlikely to be reflected in a care plan. Where social inclusion is considered at all it tends to be assumed that stable mental health will of itself lead to social inclusion. There is not enough recognition of the loss of skills, confidence and ambition that people can experience as a result of mental health difficulties. There is often not a very sophisticated understanding of the potential positive effects on a mental health condition of experiencing greater social inclusion.

What gaps would you identify in current service provision?
Services are usually very generic in their approach to mental health difficulties; there is little reflection in the way services are constituted of the specific needs of individual communities or groups. Mental health services do not adopt a proactive approach to joining their efforts up with those of other agencies and organisations, for example those involved with meaningful education and employment.

Students as a group suffer greatly as a result of their needs not being properly understood or addressed. This is demonstrative of the separated nature of mental health services, for whilst there is a large push to increase participation in HE, mental health issues remain largely invisible as an issue in the education sector, and education remains largely invisible within mental health services.

Targeted services, which were more engaged in the reality of the communities that they serve would lead to a different ethos which was more aimed towards social inclusion. Services which for the most part manage chronic mental health difficulties cannot be expected to also offer an optimistic and supportive

service aimed at promoting social inclusion, or even better at preventing social exclusion.

Nottingham is not unusual in having approximately 1 in 6 of its adult population involved in HE. The age groups of these participants correspond largely with the age groups which are most vulnerable to first-episode psychosis and also have the greatest risk of suicide. There are, however, no services with any specific remit to meet the needs of this group.

Are there examples of good practice in service provision by the voluntary/community sector which could be disseminated more widely?
Nottingham Trent University (NTU) has had considerable success in supporting students with mental health difficulties in studying at Higher Education level. This has included running a mental health worker scheme which helps students with mental health difficulties cope with the effects of their mental health difficulties in their education. The support emphasises progress in educational terms and has a profound impact on preventing students unnecessarily dropping out of their education.

Although it is not quantifiable the service is believed to have a significant effect in terms of preventing students who may be vulnerable to developing more profound mental health difficulties from becoming “career mental health patients.”

The support systems also allow for recommendations to be made to other parts of the University about what can be done to ensure the students are not unfairly discriminated against because of their mental health difficulties.

NTU has, we believe, accessed funding through the Disabled Student Allowance scheme and used this to the benefit of students more than any other University. This has been achieved despite the DSA scheme operating in a way which puts students with mental health difficulties at a disadvantage compared to other students with disabilities.

Are there examples of good practice in other countries which we could learn from?
Australia has far more services which seem engaged with the reality of young peoples’ experiences of mental health difficulties and set the issues in the context of real everyday life.

What would be the best way to measure progress in reducing social exclusion for adults with mental health problems?
Social exclusion has to be measured across a broad range of indicators or there is a danger that it merely reflects progress in isolated areas which would not therefore reflect progress in terms of social inclusion which, by definition, has to be a holistic concept.

Indicators which should be seen as significant are the same ones which would be seen as significant for society as a whole. For example, the Newcastle Declaration on Psychosis called for comparable levels of participation in

education for people who had experienced psychosis as their peers. The government's target of 50% participation in HE among people under 30 should therefore be seen as applying every bit as much to students with mental health difficulties.

At present there is no reliable indicator of participation by people with mental health difficulties in HE because a minute proportion of students declare their difficulties on their UCAS forms out of a belief that this will harm their applications. Universities should be judged on how many people declare mental health difficulties on applications. Such a measure would encourage Universities to make efforts to counter perceived and real prejudice towards people with mental health difficulties and would aid the targeting of support aimed at preventing social exclusion occurring. It would also in itself be indicative of progress.

The question on UCAS forms is currently phrased as being about disability – this should be rephrased to be about having experienced mental health problems (whether or not they would constitute a disability) and Higher Education institutions would be expected to work towards a 25% declaration rate of mental health difficulties since this reflects the incidence in society as a whole.

Other significant indicators would include mortality rates, incidence of other significant health difficulties, average income, increased levels of employment, and decreases in inactivity, a reduction in reliance on state benefits associated with social exclusion and/or inactivity (such as incapacity benefit) coupled with an increased uptake of funds such as the Disabled Students' Allowance aimed at promoting social inclusion.

Another indicator would be an increase in organisations which are proud to declare their mental health credentials. Whilst many organisations proclaim they are "positive about disabled people" there are probably very few at present which would be keen to make an explicit statement of this nature about mental health.

Is there anything else you would like to tell us?
The UMHAN group would be pleased to be consulted further on these issues and would welcome the opportunity to support the work of the social exclusion unit.