Measuring the costs and benefits of promoting social inclusion

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Abstract

Purpose – The purpose of this paper is to review representative literature on social inclusion and evaluate the usefulness of the concept in current mental health policy.


Findings – Social inclusion remains a useful concept in understanding both the causes of mental health problems and how these might best be addressed. Although measurement is not easy, it can be operationalised through a mixture of subjective and objective indicators. There is strong evidence for the effectiveness and cost-effectiveness of interventions aimed at improving social inclusion for the groups selected. These findings provide strong support for prioritising these interventions, especially in times of severe financial restrictions.

Research limitations/implications – The selection of literature for review limits the generalisability of the conclusions.

Originality/value – The paper sets out a clear and simple analysis of the concept of social inclusion and how it may be measured. It also brings together the cost-effectiveness literature on attempts to improve social inclusion for three, key high-risk groups. The paper strongly supports the value of retaining the concept of social inclusion, despite the fact that it has become temporarily unfashionable.

Keywords Social inclusion, Policy, Costs, Benefits, Outcomes

Paper type Conceptual paper

Introduction

With the advent of the recent coalition government the concept of social inclusion seems to have dropped out of the policy vocabulary. This is unfortunate. “Social inclusion” is a useful concept, it is difficult and complex, but it seems to us to have an important contribution to make to our understanding of the causes and outcomes of mental health problems. In this paper, we will discuss the problems of measuring social inclusion and the principles of cost-effectiveness evaluations in the context of health services, which are struggling to cope with reduced funding. We will then review the evidence and cost-effectiveness of three attempts to improve the long-term health and social outcomes through early intervention in three key high-risk groups:

- children and young people with behavioural problems;
- young people experiencing a first episode of psychosis; and
- adults of working age with mental health problems who are excluded from the labour market.

Finally, we will relate these findings to the current policy context associated with the new mental health strategy, No Health Without Mental Health (HMG/DH, 2011).
The measurement of social inclusion

Measures of social inclusion fall into two broad categories: “individual level” and “societal level” (Berman and Phillips, 2000). Individual level measures contain data, which reflect the situation and life experience of members of socially excluded groups (in this case people with mental health problems). “Societal” level measures – sometimes referred to as a social indicators – rely on existing data sources that characterise levels of participation in larger community samples, e.g. employment rates (Department of Work and Pensions, 2007); number of rough sleepers (Palmer et al., 2007); etc. Both kinds of measures are relevant to policy makers, but individual level measures are of most interest to most clinicians.

Apart from the usual psychometric properties of inter-rater and test-retest reliability, any measurement tool for social inclusion must have demonstrable validity. Thus, it must “converge” with other instruments measuring similar concepts, e.g. poverty, citizenship, social capital, quality of life, etc. However, it must also “diverge” (discriminate) between social inclusion and these related concepts. For example, social inclusion includes aspects of poverty (e.g. exclusion from the labour market, welfare services, etc.) but adds in elements of social participation. Similarly, it includes aspects of social capital (e.g. membership of social networks, community groups and civic participation) but adds in poverty and stigma. It also overlaps with “Quality of life” measures in terms of both objective and subjective indicators. Any comprehensive measure of social inclusion must, therefore, meet these challenges to both content and discriminant validity.

While there is considerable methodological work on both the objective indicators of social inclusion and subjective measures of quality of life, no satisfactory, widely accepted measure of social inclusion yet exists. However, a number of indicators consistently recur in the literature. These include:

- income (poverty);
- employment (labour market participation);
- social activity (friendships, networks of social support);
- participation in family life;
- participation in leisure activities;
- participation in political and civic activities;
- community integration (involvement in “mainstream” community activities);
- access to education and training;
- access to physical health care services;
- access to mental health care services;
- access to adequate housing (including safe neighbourhoods);
- involvement with the criminal justice system;
- use of the benefits system; and
- use of transport.

It should be noted that the extent of social exclusion or inclusion in relation to these indicators is not a simple binary, i.e. being “included”, is not simply the opposite of being “excluded”. Each indicator, therefore, needs to be measured on a graded dimension of participation. Huxley et al. (2006) argue that a person can only be properly regarded as “socially excluded” if it is objectively difficult for them to access certain opportunities, they recognise these barriers exist and their choices are restricted as a result of factors outside their control. In these circumstances, one would expect that they would also feel excluded from a potential set of benefits and would want to increase their participation if possible (These last two caveats are necessary to account for individuals who may appear to be excluded, but do not appear to be concerned). Measures of a person’s subjective sense of “exclusion” – the perceived importance of not being able to access the benefits of inclusion and the desire...
for more (or less) participation – are more difficult to quantify. The subjective component of ‘quality of life’ ratings (Gaite et al., 2006) is relevant here, but more work needs to be done to develop these measures specifically in relation to social exclusion.

Evaluating the cost-effectiveness of interventions to promote social inclusion

Any specific policy or intervention aimed at increasing social inclusion among people with mental health problems needs to be justified in the first instance on the basis of evidence of its effectiveness: does it work? In other words, how much does the intervention improve outcomes in the various domains of social inclusion discussed above? Evidence of effectiveness is necessary, but not sufficient to justify funding of the intervention in question. This requires meeting the further test of value for money: not only ‘does it work?’ but also ‘is it worth it?’ All interventions entail the use of scarce resources and, particularly at a time of severe constraints on public spending, difficult choices have to be made between different ways in which these resources could be deployed. Pursuing one course of action necessarily precludes another (“opportunity cost”) and prioritisation is, therefore, inevitable. In order to prioritise sensibly, an economic evaluation aimed at measuring and comparing all the costs and all the benefits of alternative interventions (including the option of not intervening) is required. This clarifies the nature of the choices to be made and attempts to ensure that all resources are used as productively as possible. Of course, in the end, all decisions about the relative costs and benefits of different actions will be subjective.

The remaining sections of this paper briefly review three areas where there is good evidence to suggest that interventions exist which are both effective and cost-effective in improving health and social outcomes among people with mental health problems, so strengthening their social inclusion. In each case, this evidence supports their consideration as priorities for service development, especially in these tight financial times.

Children and young people

Longitudinal studies undertaken both in the UK and in other countries indicate a high degree of persistence (continuity) between adverse mental states in childhood and those in adult life (Kim-Cohen et al., 2003). For example, the most common mental health problem in childhood is conduct disorder, which affects nearly 6 per cent of children between the ages of 5 and 16 (Green et al., 2005). Longitudinal data suggest that this disorder persists into adulthood in 40 per cent or more of cases and is specifically associated with family disadvantage in early life. Childhood conduct disorder is strongly predictive of a range of poor outcomes in adult life, including criminality, substance misuse, poor educational and labour market performance and disrupted personal relationships (Stewart-Brown, 2004). These are all major risk factors for social exclusion.

The social and economic costs of conduct disorder are high, with one study suggesting that by age 28, the costs incurred by the public sector for individuals with conduct disorder were about ten times higher than for those with no problems, with an average cumulative cost since childhood of around £70,000 (Scott et al., 2001). Nearly, two-thirds of the costs for those with conduct disorder were borne by the criminal justice system; those falling on the NHS were a relatively small proportion of the total.

The main form of intervention aimed at addressing conduct disorder in early childhood is parent training. These programmes are designed to improve parenting styles and parent-child relationships and can be targeted at parents of children who are at high risk of developing conduct disorder. The most successful programmes rely on behaviour management approaches. The effectiveness of parenting programmes has been estimated using data from studies included in a recent systematic review of 57 randomised controlled trials using a statistical approach to compare the proportion of children with clinically relevant conduct disorder post-treatment in the intervention and control groups (Dretzke et al., 2009). The analysis showed that on average parenting programmes resulted in a 34 per cent reduction in clinical cases of conduct disorder from pre- to post-intervention compared with control groups (Knapp et al., 2011). Economic modelling based on this analysis indicated
that over a 25-year period parenting programmes generate benefits valued at over £9,000 per child, including savings in public spending (NHS, education system and criminal justice system) of over £3,000 (Knapp et al., 2011). This was based on very conservative assumptions of numbers treated (a take-up rate of only 37 per cent and a drop-out rate of 44 per cent). Limitations in the data also meant that no allowance could be made for a number of potential long-term benefits such as improved employment prospects and reduced adult mental health problems. The figure of almost £9,000/child benefit is, therefore, probably an underestimate. In comparison, the average cost of an eight to 12-week group-based parenting programme is estimated at £952 per family and that of an individual intervention at £2,078 (Puig-Peiro et al., 2010). Assuming 80 per cent of families receive group-based interventions and 20 per cent receive individual interventions, in line with NICE guidance, the average cost of the intervention works out at £1,177 per family. On these figures, the total benefits of parenting programmes, therefore, exceed costs by a factor of around 8 to 1.

A new family intervention, which builds on early intervention to improve parenting skills has been developed and this is known as “multi-systemic therapy” (MST). This is a multi-faceted, short-term, home and community-based intervention for families where there are children and/or adolescents (aged 10 to 17) with severe psychosocial and behavioural problems (Hennggeler, 1998). Littell et al. (2005) have conducted a meta-analysis of the available RCT evidence relating to MST (n = 8 trials) and concluded that there was insufficient evidence regarding its effectiveness compared with alternatives to come to any definitive conclusions. Results were, “inconsistent across studies that vary in quality and context” (Littell et al., 2005, p. 4). However, there was no evidence that MST had harmful effects. A more selective review commissioned by the cabinet office covered similar ground, but suggested that there were positive results demonstrating reduced adult offending in a 13-year follow-up compared with individual therapy (Utting et al., 2007). Apart from the inconsistent nature of these results, there remain a number of questions regarding the effectiveness of MST. Which of its several facets contribute most to favourable outcomes? Is it related to the specific therapies employed, or is it just a reflection of the intensity of the intervention? (24/7, available for 12 weeks). How durable are any long-term effects? Is MST cost-effective? As indicated, it is a very intensive intervention, but if the long-term effects are replicated, then there are likely to be very considerable cost savings in terms of the demands on other health, social and criminal justice services by these young people later in life. These questions wait to be answered before one could make adequate, evidence-based policy recommendations.

Young people experiencing a first episode of psychosis

Each year in the UK about 7,500 people develop a first episode of psychosis and in about 80 per cent of cases the onset occurs in people aged 16-30. Psychosis can lead to long-term, even lifetime, problems, putting a minority of those affected at particularly high risk of social exclusion (Warner, 2009). The Social Exclusion Unit (2004) found that only 12 per cent of people with psychoses living in the community were employed, often in low-paid, insecure jobs; one in four tenants with mental health problems were likely to be in serious rent arrears; and they were three times more likely to be trying to cut down on basic utilities (gas, electricity, water and telephone). According to another survey of activities in the previous two weeks, 39 per cent had no friends or had met none, 34 per cent had not gone out socially and 50 per cent had spent no time on any interest or hobby other than watching TV (Parker et al., 2007). It is also well established that the physical health of people with psychoses is much worse than in the population at large (Seymour, 2003; Marder et al., 2004).

The case for early intervention in psychosis rests on clear evidence that late treatment results in poorer long-term outcomes. The cognitive and psycho-social damage caused by psychosis occurs mainly during the early stages of the illness (up to five years after onset) after which a plateau of disability is reached which then predicts the level of disability at 15 years (Harrison et al., 2001). The greater the delay in providing treatment, the greater the risk that individuals will experience more long-term problems, including decreased probability of complete remission, increased resistance to conventional treatments, unemployment, impoverished social networks and loss of self-esteem (Marshall et al., 2005). Suicide is also a
significant risk in the early phase of illness: one in ten people with psychosis commits suicide and two-thirds of these deaths occur within the first-five years (Department of Health, 2001).

Research studies from a number of countries now provide evidence that early intervention after the first episode of psychosis is not only feasible, but also cost-effective (Addington, 2007). Compared with standard mental health care, early intervention services report shorter durations of untreated psychosis, lower relapse rates, reduced use of legal detention, reduced hospital admissions, better service engagement, higher client/carer satisfaction and lower suicide rates. There is also some evidence that intervention in the prodromal (pre-psychotic) phase, based on the identification of high-risk individuals, can delay or even prevent the onset of first-episode psychosis (McGorry et al., 2002; Morrison et al., 2004, 2006). In most studies, these benefits have been demonstrated over relatively short periods of time (one or two years); however, there is now increasing evidence to suggest that at least some of the gains persist into the longer term.

Concerning cost-effectiveness, a study carried out at the Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne found that health service costs per patient were reduced by about 30 per cent over the first 12 months of treatment compared with the previous model of care (Mihalopoulos et al., 1999). A subsequent eight-year follow-up has found that over a longer period, the EPPIC sample incurred only about half the costs of the pre-EPPIC group (McGorry, 2007). Most of the savings resulted from lower use of inpatient services. Positive clinical outcomes for the EPPIC sample were also maintained over the eight-year follow-up, indicating that early intervention was both more effective and less costly than standard care. Economic analyses of early intervention services in London broadly confirm the findings of the EPPIC study (McCrone et al., 2007). This evidence, therefore, clearly justifies a policy of early intervention for young people with first episode psychosis on clinical, social and economic grounds.

**Employment**

Not having a job is perhaps the single most important cause of social exclusion among adults of working age. There are currently around 1.3 million people with a mental health condition in receipt of long-term unemployment benefits and a further one million who are workless, but not in receipt of benefits (Perkins et al., 2009). People with long-term mental health problems also have the lowest employment rate of any of the main groups of disabled people – <25 per cent – compared with a rate of around 75 per cent in the working-age population as a whole (Labour Force Survey, 2005). Unemployment is usually associated with poverty, which contributes to social isolation and low self-esteem. In addition, prolonged unemployment is linked to a significant deterioration in mental and physical health, with increased risk of suicide and premature death (Black, 2008). Conversely, having a job can lead to a reduction in psychiatric symptoms, fewer hospital admissions and reduced service use, in addition to the benefits of increased income, social contact and sense of purpose (Waddell and Burton, 2006). It also figures prominently in the recovery stories of many individuals (Shepherd et al., 2008).

The low rate of employment among people with mental health problems is not generally due to an unwillingness to work (quite the reverse). Several surveys have reported evidence indicating that between 70 and 90 per cent of people with mental health problems in the community want to gain or return to work (Rinaldi and Hill, 2000; Secker et al., 2001) although they anticipate problems in doing so (financial instability, stigma from employers and workmates, dangers of relapse, etc.). These anticipatory fears are perfectly realistic. However, the major obstacle to helping people with mental health problems to return to work is probably the low expectations regarding the feasibility of achieving paid employment which are held by the public in general (Social Exclusion Unit, 2004) and by mental health professionals specifically (Marwaha et al., 2008). Low employment rates may also reflect shortcomings in traditional methods of vocational rehabilitation, particularly their emphasis on extended preparatory training prior to engagement with the labour market. This continues despite a substantial body of evidence in support of an approach which aims to minimise the length of pre-placement preparation and integrate employment specialists fully into clinical teams (“Individual Placement and Support (IPS)”, see Becker et al., 1994). There is now very
strong evidence from a number of different countries that IPS is superior to traditional approaches in terms of helping people with mental health problems back to employment (Crowther et al., 2001; Bond et al., 2008; Latimer et al., 2006; Porteus and Waghorn, 2007; Rinaldi and Perkins, 2007a, b). The evidence includes a multi-centre, randomised controlled trial covering six sites in Europe (The Netherlands, Germany, Italy, Bulgaria and Switzerland). In every case IPS was superior to the local alternative in terms of helping people find jobs and continue in paid employment (Burns et al., 2007). As might be expected, although factors like local employment rates and benefits arrangements had some effect on employment outcomes, these were insignificant compared with whether or not the clients received IPS.

IPS has seven key principles:

1. competitive employment is the goal (whole or part-time);
2. no selection criteria are applied, beyond expressed motivation, i.e. accessible to all those who want to work;
3. focus on consumer preference – “fitting the job to the person, rather than the job to the person”;
4. based on rapid job search and placement aiming to minimize time spent on pre-employment assessment and training – “place-then-train”, not “train-then-place”;
5. relies on close working between employment specialists and clinical teams into which they are embedded;
6. provides individualized, long-term support with continuity; and
7. includes access to expert Benefits advice (Becker et al., 1994).

In order to ensure that IPS is delivered according to an evidence-based approach, these principles have been brought together in a “fidelity scale” consisting of 25 items, grouped in three sections (staffing, organisation and services). Each item is arranged on a five-point scale, with each point clearly anchored by behavioural descriptions (copies are available from the Dartmouth IPS Supported Employment Centre, http://dms.dartmouth.edu/sec/). The available outcome evidence suggests that the closer the fidelity of the service to the standards described in the scale, the better the employment outcomes. Only one evaluation of an IPS-type model has emerged in this country with negative findings (Howard et al., 2010) and this appeared to be directly attributable to a lack of fidelity to the evidence-based model (Latimer, 2010).

In general, employment rates for people who are helped to find and sustain open employment through IPS average 40-50 per cent, compared with 10-20 per cent for other approaches. Those supported by IPS also work significantly more hours per month and have higher earnings and better job tenure. There is no evidence to show that the higher rates of employment resulting from IPS have an adverse effect on clinical wellbeing and relapse. Indeed, in the European trial mentioned above, IPS was associated with reduced rates of psychiatric admission and less-time spent in hospital. Follow-up studies conducted after eight to 12 years confirm that the greater effectiveness of IPS is sustained over the longer term (Salyers et al., 2004; Becker et al., 2007).

These positive findings regarding effectiveness are generally supported by the evidence on cost-effectiveness. Thus, a recent review has suggested that IPS is generally less expensive to implement than alternative methods of vocational support and there are also some indications of overall cost savings in terms of reduced mental health service use and reduced reliance on welfare benefits. This is mitigated by the fact that most service users take up part-time positions, so limiting the scope for benefit savings (Latimer, 2008). The cost-effectiveness of IPS is likely to emerge more strongly as more evidence becomes available on long-term outcomes.

On this basis, there is very strong evidence to recommend implementation of IPS as routine practice for specialist mental health services which aim to improve the employment rate (and thereby social inclusion) of people with long-term mental health problems who are currently
unemployed. This could be funded by the closure of existing “non-IPS” work and day services which do not deliver comparable employment outcomes (Sainsbury Centre for Mental Health, 2009).

Conclusions
This brief review has argued that “social inclusion” remains a useful concept in understanding the causes of mental health problems and how these might best be addressed. Although the measurement of social inclusion is not easy, it can be operationalised through a mixture of subjective and objective indicators. In addition, there is strong evidence for the effectiveness and cost-effectiveness of interventions aimed at improving social inclusion for a number of high-risk groups. This evidence provides strong support for prioritising these interventions, especially in these times of severe financial restrictions.

To bring these discussions up-to-date, it is interesting to note that, although the term “social inclusion” barely figures in the recent mental health strategy No Health Without Mental Health (just two mentions); nevertheless the concepts of social integration remain prominent. For example, key objective ii. (p. 7) is “More people with mental health problems will recover” and it goes on to state that this means:

More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.

These are all socially inclusive goals. They are reinforced by the Adult Social Care and Public Health outcomes frameworks (pp. 70-8) which are studded with socially inclusive outcomes (e.g., “proportion of adults in contact with secondary mental health services in employment”, “proportion of adults in contact with secondary mental health services in settled accommodation”; etc.). Plus ça change […]

References


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Further reading


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