Social inclusion of people with severe mental illness: a review of current practice, evidence and unmet needs, and future directions

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Social inclusion means being able to participate in activities valued within one's community or wider society as one would wish. People with severe mental illness (i.e., psychoses, bipolar disorder, and severe depression) experience some of the highest rates of social exclusion compared to people with other disabilities. This is the case regardless of the availability of specialist mental health services. Therefore, questions arise about the extent to which mental health services can and do prioritize social inclusion as a goal of service provision, and what strategies are needed outside of mental health services, at the levels of legislation and policy, statutory services, and civil society. In this paper we consider what social inclusion means in different cultures and contexts, since the value attached to different activities varies by culture and by life stage and gender. We discuss the subjective impact of low levels of social inclusion in terms of loneliness, and the evidence base for interventions to address it. We then turn to strategies to increase observable forms of social inclusion. While evidence for some interventions is largely based on the Global North, we use evidence and examples from the Global South to the extent that we have found them. We also consider the predominant frameworks for social inclusion used in health services, followed by alternatives that may offer a more empowering approach to social inclusion for some people. We then describe strategies to reduce social exclusion through interventions to address stigma and discrimination, directed at key target groups or at population level. We make recommendations for policy makers, researchers, health professionals, and advocates based on the evidence and examples we have found, covering various forms of legislation, services and mental health research. Our conclusions identify the next steps for interventions, including development, evaluation, implementation or modification for better contextual adaptation.

Key words: Social inclusion, severe mental illness, social roles, loneliness, employment, community engagement, stigma, discrimination, social prescribing, advocacy

Social inclusion means being able to participate in activities valued within one's community or wider society as one would wish. People with severe mental illness (i.e., psychoses, bipolar disorder, and severe depression) experience some of the highest rates of social exclusion in terms of both its subjective and observable aspects. For example, they report very high levels of feeling lonely[1] and experience higher rates of unemployment than the average for people with a disability. Unemployment, social isolation and the resulting poverty and loneliness have severe consequences for both quality of life and life expectancy[2,3]. Therefore, increasing social inclusion should be of the highest priority for health services, policy makers, and the voluntary and community service sectors.

There is no evidence that social inclusion is greater in countries with extensive mental health services compared to those without. Indeed, using employment as one indicator suggests that, in some countries, this is better in rural areas, which tend to have less service provision, than in urban areas, due to the availability of employment within the agrarian sector[4,5]. However, rapid urbanization around the world is reducing access to this way of life, and rural areas are not free of other forms of social exclusion.

The finding that over 80% of people with psychosis reported loneliness in an Australian study[1] emphasizes the insufficiency of keeping people out of hospital as a service goal, and the lack of effective use of community assets besides health services to promote social inclusion. At a time of widespread scaling-up of mental health services, for example through primary care, and of mental health professional workforce shortages, it is important to question the efficiency, in relation to social inclusion, of mental health care provided via either primary or specialist health services, and to consider both the role of other community assets and their relationship to organizations providing mental health care. It is also important to identify what interventions require tailoring to people with severe mental illness, and to establish an evidence base for social inclusion-enhancing interventions.

One response to low levels of social inclusion could be to work to reduce structural discrimination and interpersonal stigma. There is some evidence to support this strategy. For example, over the course of the first six years of England's Time to Change programme to reduce mental health-related stigma and discrimination, serial surveys of mental health service users indicated a fall in the median number of life areas in which they experienced discrimination in the last 12 months[6]. Carefully designed, multi-year stigma reduction programmes have been conducted or are currently running in a number of countries[7].

However, we do not believe that stigma reduction alone would be sufficient, for several reasons. The first is the lingering effect of anticipated discrimination. Studies in countries of all income levels highlight the extent to which people avoid seeking employment opportunities due to their anticipation of discrimination, even if they have not directly experienced it. Anticipated discrimination affects many other life areas[8], preventing people from taking up social, educational and economic opportunities, from pursuing leisure activities, and from using needed services such as physical health care[9]. On the other hand, evidence supports the protective role of employment in relation to overall levels of discrimination[10]. Thus, active strategies to increase people's ability and confidence to manage both anticipated and experienced discrimination are needed in addition to stigma reduction[11,12].

Second, even in the absence of stigma or its anticipation, the impact of severe mental illness and of relevant social risk factors, such as adverse childhood experiences, means that many people need active support to attain valued social roles, whether this be employment, education, intimate relationships or parenting. Third, reducing stigma will not address some issues that hinder effective mental health care. For example, workforce shortages affect health services such as primary care, and the profit-driven activities of the pharmaceutical industry limit access to newer medicines[13].

Fourth, people with severe mental illness belong disproportionately to a number of minoritized groups[14,15], and a high proportion of them experience poverty[16] and substance use disorders. These groups are subject to social isolation on the basis of these intersecting characteristics. We must therefore consider not only strategies to reduce social exclusion, but active social inclusion strategies at all levels and across all settings, with their different culture and service contexts, and with a view to implementation equity[17], so that intersectionality does not lead to continued or widening levels of exclusion. For researchers, addressing the aim of implementation equity requires that the design and conduct of studies fosters the involvement – as participants, advisors and peer researchers – of people with severe mental illness with such intersecting characteristics.

In this paper, we first consider what social inclusion means in different cultures and contexts. We then discuss the subjective impact of low levels of social inclusion in terms of loneliness, and the evidence base for interventions to address it. We subsequently describe strategies to increase objective forms of social inclusion, considering them at the levels of legislation, services and health professionals, with examples of each and their evidence base. We also consider the predominant frameworks for social inclusion used in health services, as well as alternatives that may offer a more empowering approach to social inclusion for some people. We then outline strategies to reduce social exclusion through interventions to address stigma and discrimination, directed either at key target groups or at the population level. Finally, we make recommendations for policy makers, researchers, health professionals, and advocates covering various forms of legislation, services and mental health research.

THE MEANING OF SOCIAL INCLUSION IN DIFFERENT CULTURES AND CONTEXTS

Social inclusion encompasses social connectedness, meaningful participation in community life, and freedom from stigma and discrimination[18,19]. However, its interpretation and practice are different across cultures[20,21]. This section examines how social inclusion is understood and practiced in different cultures and contexts.

Individualism

Individualism is dominant in Western countries such as the US, the UK and Australia. It emphasizes personal autonomy, self-reliance, and the importance of individual rights and goals[22]. Social inclusion programmes in this context place strong emphasis on individual achievement and independence[23,24]. Success is often defined by personal milestones, such as securing independent housing, obtaining competitive employment, and engaging in self-advocacy[25-27].

For instance, the Americans with Disabilities Act focuses on ensuring individual rights and providing accommodations in public spaces, underscoring the importance of personal autonomy and equal opportunities[28]. The UK is pioneering a mental health innovation called Recovery Colleges[29], which are learning-based mental health recovery support systems offering information, social support and skill development for people with mental health symptoms, carers and staff[30]. The Clubhouse Model in the US emphasizes member-driven recovery through work and community, where individual strengths and choices are central[31]. Australia's National Disability Insurance Scheme, a major initiative providing support to people with disabilities and their families and carers[32], emphasizes individual choice and control, enabling participants to set their own goals, and access services that promote independence, such as assistance with employment, education and daily living. The focus is on personal achievement in terms of living more independently and integrating into the community[32].

In Scandinavian countries, such as Denmark, Norway and Sweden, social inclusion reflects a hybrid approach to balance individual rights with strong social welfare systems[33,34]. Both personal autonomy and collective responsibility are emphasized, with success measured through both individual well-being and societal participation. For example, Norway's Individual Care Plan is a legally mandated, personalized plan designed to coordinate health and social services for individuals who have complex, long-term needs[35], including people with mental health conditions. It aims to provide comprehensive personal support planning with strong service integration[36]. In Sweden, Supported Employment is a well-known social inclusion scheme, supporting people with severe mental illness to obtain an employment[37]. A job coach offers support not only for the person with severe mental illness and the employer, but also for the person's colleagues, emphasizing collective responsibility[37].

Self-effacing collectivism

Self-effacing collectivism is dominant in East Asian countries, including Japan, South Korea and China. It values strong commitment to social harmony, interpersonal obligations, and adjustment to social norms and expectations. Conflict avoidance is the primary way to maintain social relationships. Social inclusion in these countries is deeply embedded in family and group contexts[38-40]. Success is often measured by how well someone maintains family harmony and fulfils social roles[38,41]. For instance, in Japan, the condition called *hikikomori* (a severe form of social withdrawal) is not only seen as problematic for the individual, but also as disrupting family harmony and social obligations[42,43].

Social inclusion programmes in Japan often prioritize social harmony through interventions such as community-based integrated care systems[40]. Singapore's National Mental Health and Well-Being Strategy emphasizes family and social support[44], including mental health education. In China, the 686 Programme actively involves family members in treatment and rehabilitation plans, offering psychoeducation and support to enhance understanding of mental health conditions. Additionally, community-based rehabilitation centres provide a platform where individuals with severe mental illness and their families engage in social and vocational activities, fostering a supportive network within the community[45].

Argumentative collectivism

Argumentative collectivism values social harmony, but through active engagement in argumentation. This type of collectivism is dominant in regions such as South Asia. Social inclusion in this context tends to prioritize community engagement and open dialogue. In India, health care workers who are involved in social inclusion programmes for people with severe mental illness are often viewed as extended family members, and participate in open discussions in families and communities[46].

In a peer-led, community-based, participatory group intervention for young people with psychosocial disabilities in Uttarakhand, India, outcomes such as forming new friendships, community involvement, and confidence in communicating were highlighted[47]. Likewise, pregnant women suffering from anxiety in Pakistan reported that family connection and their ability to open up and discuss their mental distress were key components to address their condition[48].

Self-assertive collectivism

Self-assertive collectivism is a cultural orientation in which individuals maintain strong group ties and collective identity, but are also encouraged to express personal opinions, assert themselves, and take initiative to protect and strengthen their group. This approach tends to prioritize safeguarding the ingroup by using individual resilience and strength through self-assertiveness[49]. This type of collectivism can be observed in Arabic countries.

In these countries, social inclusion is often interpreted through religious participation and adherence to religious values[50]. Being "included" encompasses active participation in various aspects of community life, including religious, family, and broader social networks, and following prescribed social norms[51,52]. A common approach to mental health support involves engaging religious leaders and incorporating faith-based practices[53].

In United Arab Emirates, despite the well-invested and highly accessible medical services, religious counsellors (*Mutawa*) remain highly in demand[54]. In Qatar, recent national mental health strategies were implemented to shift from hospital-based psychiatric care to a community-based care based on the Islamic faith[55,56]. In Saudi Arabia, social inclusion for people with mental health issues combines religious and professional care. Mosque-based support groups and regular consultations with psychiatric professionals and religious leaders play a central role[57-59].

In many Arabic cultures, strong family and tribal ties provide vital emotional and practical support for individuals with mental health conditions, with family members often actively participating in caregiving and community engagement. Support from tightly connected communities can have an important role in resolving mental health crises, including suicidal behavior[60].

Expressive collectivism

Expressive collectivism aims to achieve social harmony through personal expression[49]. This cultural orientation maintains that personal expression and sharing one's authentic self can enhance social cohesion and mutual understanding, rather than threaten group harmony[49]. Latin American countries often exhibit this cultural orientation.

For example, Brazil's *Programa de Volta para Casa* exemplifies this approach through its integration of theatrical or musical elements as therapeutic tools, where emotional expression and family participation in celebratory gatherings are regarded as central to recovery[61,62]. Similarly, Colombian educational organizations aiming at social inclusion for young people with mental health issues often employ expressive programmes[63].

Connection to ancestral traditions

Traditional Indigenous communities, such as the Maori in New Zealand or First Nations in Canada, often interpret social inclusion through connection to ancestral traditions[64].

For example, *Te Whare Tapa Whā* in New Zealand is a holistic social inclusion model, rooted in Maori cultural values, focusing not only on mental and physical health, but also on family and spiritual health. Health is based on connection to the environment, ancestors and heritage[65]. Similarly, Canada's First Nations Mental Wellness Continuum Framework integrates traditional healing with modern care[66], regarding culture as the foundation for a good life, and prioritizing Indigenous people's cultural knowledge (e.g., connection to the land and community) and language.

THE ROLE OF LONELINESS

Loneliness, the negative affective state resulting from a subjectively experienced gap between someone's desired and actual social relationships[67], is common among people with mental health conditions. Over 80% of individuals with psychosis reported feeling lonely in one large Australian study[1]. Loneliness is negatively associated with both social inclusion and quality of life in mental health populations[68].

Loneliness is typically only weakly or moderately correlated with the amount of social contact that someone has[69]. Rather, it is related to the development or sustenance of meaningful social connections, which provide emotional support, understanding, acceptance, and a sense of belonging[70,71]. Addressing loneliness is an important element of improving social inclusion for people with mental health problems.

In the general population, a wide range of interventions can reduce loneliness[72,73], including social approaches such as community linkage or befriending, and psychoeducation. But the evidence base for how to help reduce loneliness for people with severe mental health conditions is thinner and less promising: a systematic review published in 2020[74] included nine trials in people with severe mental illness, with subjective social isolation or loneliness as main outcomes. The interventions tested in these trials, all in high-income countries, included psychoeducation, social skills training, and supported socialization, or combinations of these. Despite positive findings in some studies regarding the amount of social contact or support received, none yielded positive results on the main measure of loneliness or subjective social isolation[74]. An update of this review (in preparation) indicates that the field has not moved on substantively.

Why might it be harder for people with severe mental illness to develop meaningful social relationships and reduce loneliness? Two recent systematic reviews collate findings from qualitative studies about the subjective experiences of loneliness among people living with psychosis[75] and across a range of mental health conditions[76]. Contributing factors identified in these reviews are consistent with quantitative and theoretical literature, and are summarized below.

First, people with severe mental illness have smaller social networks than the general population[77], and social network size does not typically increase over the course of contact with mental health services[78]. Existing friends and family provide companionship and can introduce us to their friends and acquaintances. Going to new groups and social activities can be less daunting with a friend. A small social network is a difficult starting point for addressing loneliness and developing new social relationships.

Second, as already noticed, people with severe mental illness experience high levels of stigma, and this is independently associated with loneliness[79]. They report experiencing hostility, ridicule and fear from others[75,76]. These negative attitudes extend to sexual stigma, with people with mental health difficulties being viewed as less suitable romantic partners[80] and more sexually exploitable[81]. While these attitudes are not universal, they make it harder to navigate social relationships. Moreover, in the context of realities of stigma and discrimination, people with severe mental illness may anticipate negative reactions from others and avoid social contact rather than risk rejection[75]. People may also absorb the negative attitudes of others, and come to doubt their own likeability or ability to forge relationships[77]. This may result in “self-stopping behaviors”[82] which limit opportunities to develop social connections that might reduce loneliness.

Third, symptoms of illness may be direct barriers to social interaction. For example, anhedonia and blunted emotional response reduce pleasure from social interaction, and social anxiety, exhaustion or acute psychotic symptoms make it harder to initiate it[75,76]. Some people with severe mental illness have described the need to balance their desire for social contact with the demand to limit stresses to maintain health, which could deter them from social contact. This was a recurring theme in a recent clinical trial, in which participants emphasized the emotional burden of taking part in a programme to reduce loneliness, even though the extra support was wanted[83].

Finally, barriers to social connection for people with severe mental illness are not all psychological. Lack of money to join social activities, transport and physical access challenges, and lack of information about available local groups all make it harder to take action to extend social interaction and reduce loneliness[75,83].

When asked, people with severe mental illness typically say that they would like help to enhance their social relationships[84], including romantic and sexual ones[85]. But they often find it hard to talk to staff in mental health services at all about their needs and wishes for social connection and reducing loneliness, and are rarely offered the help they want[86-88]. This may be partially explained by the lack of established models of support to help with loneliness in mental health care. Yet, a wide range of ways by which services could help these people have been developed. Four broad groups of interventions have been proposed[89]: changing cognitions; social skills training and psychoeducation; supported socialization or having a "socially-focused supporter"; and wider community approaches. However, all require further development and evaluation.

Recent years have seen increasing interest in supporting people to reduce loneliness, in clinical and public health contexts. Two current randomized controlled trials will add substantially to the evidence base for social interventions on loneliness in psychosis[90] and treatment-resistant depression[91]. Nonetheless, more research is needed. While the most effective intervention models will have to be established through clinical trials, creative collaborative initiatives in mental health practice are warranted to address the common unmet need for support with loneliness among people with serious mental health conditions, thus improving their social inclusion.

LEGISLATION

We identify four types of legislation that should be scrutinized for its impact on social inclusion of people with severe mental illness: equality legislation; legislation that includes discriminatory content specific to people with a mental health problem; criminalization of behaviors associated with mental disorders, including suicide and suicide attempts and use of illicit substances; and mental health legislation and policy.

Equality legislation

In the European Union (EU) and the UK, the European Employment Equality Directive and the subsequent EU Charter of Fundamental Rights have led to harmonization of legislation for people with disabilities along with other protected characteristics (age; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; and sexual orientation). Two countries (the UK and Germany) include disability in wider equality legislation. In Germany, both general equality and disability legislation exists. In the UK, the Equality Act 2010[92] superseded the previous Disability Discrimination Act and covers all protected characteristics. We discuss this Act here as a comprehensive piece of legislation, to exemplify how disability can be defined; types of discrimination to be covered; coverage of pre-employment questions about health and disability; and consideration of when disclosure of a disability is needed for aspects of legislation to be implemented.

The Equality Act 2010 defines disability as a “physical or mental impairment which has a substantial and long-term adverse effect on the ability to carry out normal day to day activities”. The Act prohibits several types of conduct. First, it prohibits direct discrimination, in which someone discriminates against a disabled person because that person is disabled. Second, it covers indirect discrimination: a person with a disability can claim that a particular practice or provision disadvantages persons sharing the same disability as the applicant. Third, discrimination arising from disability occurs when an organization treats a disabled person unfavorably because of something connected with that person’s disability (for example, an employer dismisses a worker because she has had three-month sick leave). The Act also refers to third-party harassment due to disability. Employers are liable for harassment of their employees by a third party (e.g., a customer) when: the employer knows that the employee has been harassed; harassment occurred at least twice; and the employer did not take reasonably practicable steps to prevent harassment recurring.

A significant feature of the Equality Act is that it makes it unlawful for employers to enquire of an applicant’s disability or health, until that person has either been offered a job or been included in a pool of candidates to be offered a job when a suitable position arises. This restriction is qualified by several exclusions: questions required for national security vetting; making reasonable adjustments to enable the disabled person to participate in recruitment; establishing whether a job applicant would be able to undertake a function intrinsic to the job, with reasonable adjustments in place as required; monitoring diversity in job applications; supporting positive action in employment for disabled people; and, if the employer applies a requirement to have a particular disability, establishing whether the applicant has the disability. Nothing in the Act prevents employers asking about health-related questions once recruitment decisions have been taken.

While the Equality Act does not obligate disclosure of disability, a claim for direct discrimination or discrimination arising from disability can only be made when the employer/organization knew or ought to have known that the person was disabled; and no duty arises to provide “reasonable adjustments” if the employer/organization does not know or could not reasonably be expected to know that a person has a disability. However, in some circumstances, disclosure may be obligatory – for example, if a job environment is such that one’s disability could present a risk to one’s health and safety or that of colleagues.

Legislation with specific discriminatory content

In theory, legislation that covers any area of life could specify an exclusion of some people with mental health problems from valued social roles, particularly if it predates equality or disability legislation. The exclusionary criterion may for example apply to anyone previously and/or currently detained in hospital for treatment under mental health legislation. Identifying whether such exclusions exist is no small task. Doing so has taken either of two approaches; we present an example of each below. One involves the scrutiny of all legislation within one country, with a view to changes within that country across multiple pieces of legislation; the other examines legislation from multiple countries covering a specific life area to inform international action to promote national level change.

Scrutiny of all legislation in one country

The UK Mental Health (Discrimination) Act 2013[93] brought about changes to help protect individuals against discrimination on the grounds of mental health, with the broader aim of destigmatizing mental illness. It abrogated provisions in several pieces of legislation which could prevent people with mental health conditions from serving as members of Parliament, members of the UK's devolved legislatures, jurors, or company directors.

Members of Parliament had previously been disqualified if they had been detained under the Mental Health Act 1983 for more than six months. The Juries Act 1974 disqualified people from jury service if they were "liable to be detained under the Mental Health Act 1983" or were resident in a hospital due to mental disorder. Companies Regulations for England and Wales from 2008, 2009 and 2011 provided for the termination of a director's appointment on grounds of mental health problems.

Scrutiny of legislation across multiple countries regarding one life domain

In 2010, the EU Agency for Fundamental Rights published a report entitled "The right to political participation of persons with mental health problems and persons with intellectual disabilities"[94]. The project was started after the entry into force of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD)[95] in 2008, and in anticipation of the EU's ratification of it, which took place in December 2010. At the time of the project, the right to political participation was already legally protected by international and European instruments. However, the Agency found that 15 member states excluded people with mental health problems and/or intellectual disabilities from political participation.

In many countries, deprivation of the right to vote was often directly, and sometimes automatically, linked to the loss of legal capacity, in spite of a 1999 recommendation by the Council of Europe Member States that the deprivation of the right to vote should not be automatically linked to the loss of legal capacity or any other protecting measure, such as guardianship. In other countries, individual assessments were made of a person's capacity to vote, either starting from a policy of exclusion or one of full participation. Notably, in several countries with no limitations, restrictions had only recently been lifted. For example, the UK's Electoral Administration Act 2006 abolished a common law rule that a person lacks legal capacity to vote by reason of mental health problems.

An update to the EU report in 2024 showed that considerable progress had been made, such that 14 member states allowed full participation and several others had moved from blanket exclusions to those based on assessments[96]. However, seven countries continue to automatically exclude people under legal guardianship from the voting process.

Criminalization of behaviors that may be associated with mental disorders

Suicide and suicide attempts

The majority of people who die by suicide have a diagnosable mental health problem. As of 2025, suicide and attempted suicide are criminal offences in 25 countries worldwide, such that survivors of attempts are punishable by imprisonment or fines, while family members of those who die by suicide face fines. In another 27 countries, the legal status of suicide is unclear[97]. The situation has recently shifted in both directions. In 2022, Pakistan decriminalized suicide, while Jordan passed a new legislation imposing a fine and six-month prison sentence on those who attempt suicide.

The threat of criminalization may deter people from seeking treatment after a suicide attempt; and criminalization is likely to exacerbate an attempter's mental ill health and increase social exclusion through imprisonment and the stigma of criminality. Further, there is no clear evidence that criminalization deters people from suicide[98]. Campaigns such as Decriminalize Suicide Worldwide highlight these problems and support people in the relevant countries to speak out against this legislation[97].

Substance use

In 2022, Harm Reduction International[99] reported that, out of 128 countries, 115 criminalized the use and/or possession of drugs for personal use. For those with a substance use disorder, this can reduce access to treatment and increase social exclusion due to stigma and imprisonment, and there is no evidence that the threat of imprisonment deters people from drug use. In some countries, human rights violations occur at inpatient centres for treatment of substance use dependence, such as beatings and forced labor, denial of health care, and poor sanitation[99].

Mental health legislation and policy

Historically, mental health legislation has led to social exclusion resulting from institutional care which segregated people from society and frequently failed to provide treatment of sufficient quality to promote re-inclusion. Instead, custodial care impaired people's skills for everyday living and sense of identity[100]. Modern legislation seeks to avoid this by ensuring effective treatment in the least restrictive setting possible.

An important example is India's Mental Healthcare Act 2017[101], which represents a full-scale rewriting of that country's mental health legislation with the aim of consistency with the UN CRPD[95] , that seeks "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity". The Act covers rights to good quality, geographically accessible treatment regardless of ability to pay, but also social rights such as housing when people have been abandoned by their family, as part of a commitment that "every person with mental illness shall: a) have a right to live in, be part of and not be segregated from society; and b) not continue to remain in a mental health establishment merely because he does not have a family or is not accepted by his family or is homeless or due to absence of community based facilities". However, there is the obvious risk that, without extensive implementation resources and effective destigmatization of mental illness, it will be a long time before the ambition reflected in the Act is realized.

India's Mental Healthcare Act and several recent mental health legislative reforms elsewhere provide for the expression of advance wishes in the event of loss of decision-making capacity, including preferences and specific refusals for treatment. Research shows high levels of consumer demand for these advance statements[102,103]. They offer significant benefits and opportunities to patients with severe mental illness, especially those most at risk for involuntary hospitalization[104-106]. Empowering individuals to express their treatment preferences and to promote early intervention can enhance autonomy[107], improve therapeutic relationships[108,109], reduce compulsory admissions[104-106], and facilitate social re-integration by mitigating the disruption to daily life caused by admission.

A common concern among clinicians is that advance statements may contain refusals of all psychiatric treatment[110-112] or that preferences will not meet clinical practice standards[113-115]. However, studies show that blanket treatment refusals are very rare, and that the contents are mostly compatible with standard practice[116,117]. Moreover, advance statements provide acute care clinicians with valuable information about what has or has not worked for the statement holder before, and what treatment that person will accept[116,117]. Nevertheless, potential issues such as legal complexities, communication challenges, and the risk of exacerbating rather than mitigating racial inequities in access, experiences and outcomes, as well as resource constraints, must be addressed to ensure the effective and ethical use of these documents[118].

A further implementation challenge identified in India is that mental health care is often oriented to what is best for the family, such that decision-making is done by families rather than the individual service user[119]. Therefore, research efforts must shift towards effective implementation, particularly for those who can benefit the most from advance statements[120,121].

SOCIAL INCLUSION FRAMEWORKS

Explanatory frameworks in psychiatry lie on a continuum, from those which provide explanations for mental health-related experiences at the individual level through to those locating the experiences within wider social processes.

The explanatory framework influences the importance attached to social inclusion. When mental health issues are understood as entirely decontextualized and internal experiences, system responses are oriented towards resolving the underlying issues in the individuals rather than supporting access to, or changing, their wider context. This can result in a primary focus on treating the individuals with evidence-based interventions, including compulsion in their best interests when needed, so that they can be restored, rehabilitated and made ready for future engagement in society. Some dangers of this approach are the sharp distinction between “well” and “ill”, which may create secondary harms of stigma[122], rights violations especially within inpatient and institutional care[123], secondary traumatization arising from compulsion[124], and a failure to address the underlying social, economic and environmental determinants of health[125].

By contrast, if the mental health issue is understood as entirely social, then system responses are oriented towards changing society to make space for people with mental health issues to be valued, and to lead a contributing and satisfying life. Some dangers of this approach are that people may not receive effective treatments[126]; insufficient support may be given at the individual level to help people engage in societal institutions[127]; the global under-investment in mental health services may be exacerbated[128]; and people with severe and enduring mental health issues may be left to “rot with their rights”[129].

So, explanatory frameworks matter for social inclusion. A quasi-systematic review identified 34 explanatory frameworks, organized into five types: biological, psychological, social, consumer, and cultural[130]. We group these five types into three broad categories of model: clinical (biological and psychological), disability (social), and diversity (consumer and cultural)[131].

The first category of explanatory frameworks in mental health systems, and the most widely used, is clinical models. Examples include biomedical, biopsychosocial and cognitive models. Each have a number of limitations. Biomedical models are based on the assumption that a biologically-grounded science of psychopathology is possible[132], although ongoing nosological debates[133] indicate that this assumption is not yet empirically justified. Biopsychosocial models have been criticized for prioritizing the biological[134] – as "foundational", in contrast to the psychological and social "correlates" of mental illness – and for purporting to offer, but not actually delivering, a holistic and contextualized understanding. Specific concerns include the lack of importance ascribed to subjectivity and personal meaning[135]; the epistemic weakness of these models, meaning that they should not be used as scientific frameworks with explanatory power[136]; and their focus on diagnosis over case formulation[137,138]. Finally, cognitive models place a stronger emphasis on interpretation mediating experiences. Although these models have more potential to work outwards from meaning to the social world, in practice most psychological therapy is based on similar assumptions to biopsychosocial models[139]: psychopathology differs in kind, not just degree, between clinical and non-clinical populations; psychological disorders reside *inside* the individual; and the clinician's task is to identify the disorder inside the person and provide a psychological intervention to eliminate the internal disorder. More recent psychological models, such as salutogenesis[140] and the power-threat-meaning framework[141], attempt to orient more towards societal influences on mental health and well-being, but have not yet gained international traction.

The second category of explanatory frameworks is disability models, the most widely used of which is the social disability model[134]. Disability models highlight the social foundations of disabling constraints placed on people with mental health problems. If mental distress is a socially situated response to social circumstances[142], then societal rather than individualized solutions are indicated. An example is the capabilities approach, which emphasizes the role of agency for individuals to achieve well-being. This approach was first articulated by Nobel Prize winner A. Sen[143], and then applied to health by M. Nussbaum, who explored its implications for justice, social inclusion, and citizenship[144]. The approach has relevance to disadvantaged groups[145], including those with significant mental health challenges[146]. For example, qualitative research using the theoretical lens of a capabilities approach concluded that "systems and professionals tend to shape social outcomes for people with mental distress through regulation and containment; however, the application of capabilities draws out the complexity surrounding this, the agentic, social and structural working in tension, and the power of the mental health system not removing peoples' agency"[147], which captures the intricacies many clinicians are aware of when confronted with socially situated mental health problems. Social models of disability have evolved with different emphases – e.g., the

Scandinavian emphasis on social regulation and societal participation[148] contrasts with the North American focus on civil rights[149]. An influential framework developed at Yale University emphasizes the five Rs of citizenship: rights, responsibilities, roles, resources and relationships[150]. However, the evidence is that social models have not significantly impacted on public mental health[151]. As the British Medical Association put it, “Doctors struggle to support patients’ mental health in a society which has not addressed social determinants, including poverty and racism”[152].

The third category of explanatory frameworks is diversity models, the most widely used of which is mental health recovery[153]. Other examples include Mad Pride[154] and spiritual emergence[155] . These frameworks intersect with new ways of doing research, such as survivor research[156], Mad Studies[157], and citizen science[158]. Diversity models use standpoint epistemologies to give primacy to the lived experience of individuals and groups, and criticize systems developed around professional priorities. They place an emphasis on inclusive and participatory approaches to both research and practice: “Nothing about us without us”. A recovery orientation is the most incorporated – although some argue institutionalized[159] and co-opted[160] – diversity approach within mental health systems, and has underpinned system transformation towards approaches to improve social inclusion, such as shared[161] and patient-led[162] decision-making, a focus on citizenship[163] and human rights[164], and the development of new approaches including mental health peer support work[165] and Recovery Colleges[29]. In relation to social inclusion, a recovery approach highlights the impact of social and environmental conditions[166]. This leads to foregrounding of social and community aspects, including social relations[167], social movements[168], the influence of politics on experience[169], the role of activism[170], and the imperative of social justice[171].

Explanatory frameworks as a conceptual resource to improve social inclusion are available but have not been widely used. The dominance of clinical models in relation to resource allocation and institutional power structures may favor social exclusion, both directly by responsibilization (making the individual responsible for societal issues[172]) and indirectly by channelling resources away from societal change towards individual treatment. It may be argued that addressing social inclusion will require a mental health system and workforce with conceptual competence. For example, clinicians need training in epistemic pluralism – actively cultivating a plurality of “systems of knowing”[173] – in order to develop the epistemic humility[174] to apply different models.

INCREASING ACCESS TO VALUED ROLES

Employment

The ability to provide for oneself and others is key to social inclusion across most societies[175,176]. Not only does it offer the material means needed for many aspects of community participation; it also confers social status. Consistent with this importance, employment is associated with fewer experiences of discrimination among people with severe mental illness[10], and is an aspiration held by most of these people[177]. Here we discuss increasing access to employment in terms of interventions delivered through mental health services, and actions on the part of employers.

A wide range of strategies can be used by mental health services, including: a) pre-vocational strategies (simulated work, work in protective factories and sheltered workshops); b) systematic involvement of families and wider social networks to help with job finding and facilitate work in family business; c) supported employment strategies (job analysis and matching, job finding, job coaching, trial placement, work visits to observe real work and assist with performance appraisals); and d) entrepreneurship and self-employment initiatives[178].

Supported employment strategies include a highly specified model known as Individual Placement and Support (IPS), in which employment specialists embedded in clinical teams aim to support participants who would like to work in a rapid search for competitive employment, and then provide time-unlimited and individualized support to participants and employers. Membership of clinical teams facilitates identification of people who wish to work, while liaison with the work environment allows specialists to identify supportive employers and ensure compliance with equality legislation, for example in provision of reasonable adjustments to help people perform their job.

Several recent trials of supported employment, including the IPS, have tried to improve the success of the model through augmentation with various interventions, including cognitive training/remediation[179-183], cognitive therapy[184], job-related skills training[185], and the use of the CORAL (COnceal or ReveAL) decision aid regarding disclosure to a prospective or current employer[11].

While the above strategies are in use in several countries, and many have a good evidence base[186], many people with severe mental illness spend long periods with only access to primary health care, including in high-income countries. A scoping review published in 2018 identified locating employment interventions in primary care as a promising approach, which nonetheless faces multiple barriers to implementation[187]. Vocational rehabilitation through primary care may be targeted to people with common mental health problems[188] and inaccessible or ill-suited to people with severe mental illness.

A limitation of the IPS is that it is better suited to countries in which working for an employer is the norm. Self-employment strategies may need to be emphasized where unemployment rates are high, such as in many low- and middle-income countries (LMICs). Implementation strategies also need to vary in urban compared with rural areas. For people with severe mental illness, employment rates have been found to be higher in rural areas[4,5], despite relatively poorer access to treatment. These studies identified that the agrarian sector (farming or fishing), in which the great majority of survey participants worked, is more flexible than most other sectors, and more often involves other family members, allowing for periodic disability or a degree of long-term impairment.

Employers in many countries have become increasingly aware of the impact of mental ill health on absenteeism, presenteeism, productivity and financial outcomes. However, workplace interventions usually focus on common mental disorders, as does research on such interventions[189]. The lower prevalence of severe mental illness, and the lower employment rate of people with such illness, make it less likely that employers will identify the need for interventions for this group. This may compound the difficulties faced by these people, and increase their reliance on mental health services to support them into employment. This suggests an important role for supported employment specialists: while they work with employers to support individuals, they may be able to effect changes in employer behaviors in relation to potential employees with severe mental illness. However, studies of supported employment only evaluate individual level outcomes of trial participants rather than including employer level outcomes[190].

While interventions delivered by mental health services and action by employers can promote employment, other factors contribute to the ability of people with severe mental illness to obtain work, such as the general unemployment rate, the nature of the labor market, and any welfare benefits system[191]. As a form of income replacement, welfare payments contribute to social inclusion by allowing a degree of community participation, and may facilitate fulfilment of unpaid but valued social roles such as caring for dependents or voluntary work. Lack of access to welfare benefits can lead to great financial strain on family members, destitution in the absence of paid employment[192,193], or a sense that people with mental illness are discriminated against in relation to the benefits system[194,195]. On the other hand, the impact on benefits of working and/or losing work can deter people from seeking employment[191]. While there are studies of separate services to increase the uptake of welfare entitlements[196], there is little research on how the welfare system itself can best provide both income support and support to gain employment by people with severe mental illness.

Housing

Severe mental illness can lead to homelessness even in countries with welfare systems, for example when illness and hospital admission lead to eviction for non-payment of rent or a mortgage. People with comorbid substance use disorders are particularly at risk, due to the impact of these disorders on personal finances and on social networks[197]. One way to avoid these problems is through direct rent payments to landlords, for example when someone is already behind in rent payments. This requires legislation, which has to consider what process for consulting with the tenant there should be before this is done.

The Housing First intervention provides a tenancy on condition of community mental health service engagement, as part or all the rent is covered at the start of the intervention. Several trials of this in North America and France have shown positive results on housing stability and other outcomes important in terms of social inclusion. For example, at four years follow-up, the French Housing First participant group had better quality of life in two respects (autonomy and intimate relationships), lower symptom levels and lower use of hospital services[198].

In countries with little or no disability welfare payments, lack of employment creates dependency on family members who may or may not be able and willing to support their relative. This dependency and the risk of homelessness may be exacerbated by lack of treatment in countries which also have low coverage of treatment for severe mental illness.

Education

Education can facilitate social inclusion through a wide range of opportunities for paid employment, self-employment or voluntary work, and by acquisition of skills and knowledge that facilitate choosing and developing leisure pursuits.

However, there is less research on interventions to increase access to education as compared to employment. A recent review[186] identified five randomized controlled trials (RCTs) which reported education outcomes in people with severe mental illness, though only one intervention was aimed specifically at educational outcomes rather than employment[199]. This skills training-based intervention – which taught various skills, including study, time management and basic computer abilities – was the only one to report significant benefits compared to usual care in successful enrolment in education at six months.

A pattern emerged from two studies using the IPS model[200,201] such that this intervention was associated with short-term benefits in getting participants into education. However, treatment-as-usual control groups caught up, such that similar proportions were studying at longer-term (12-24 month) follow-up. Two other pre-vocational skills training interventions which reported education outcomes, including one that added cognitive therapy[202] and another involving job-related skills training[203], did not find improved education outcomes in the medium or long term.

Recovery Colleges provide adult education tailored to people with lived experience of mental illness, while also being open to their informal supporters, mental health staff, and in many cases the public. They are based on principles of mental health recovery, co-production between people with lived experience of mental health problems and professionals, and adult learning[204-206]. The first college opened in 2009 in London, and since then numbers have grown: in 2021 there were 88 colleges in England[207], and in 2022 there were 221 colleges globally, spanning 28 countries[208]. Most colleges around the world exhibit high fidelity[209], though they operate differently. For example, relational and long-term aspects of recovery are emphasized in Japan, compared with a focus on personal learning and skills acquisition in England[210].

Recovery Colleges have potential to support social inclusion in three ways. First, intended outcomes for students with mental health issues who attend a college include improved occupational opportunities, expanded social networks and strengthening of existing relationships, less social isolation, and attainment of socially valued roles such as partner or parent[211], in addition to that of student. Second, a cluster analysis of Recovery Colleges in England identified three distinct types of college: strengths-oriented, with a health service focus; community-oriented, with a community and social connection focus; and forensic[207]. The community-oriented colleges work closely with local community networks, encourage local people with no existing connection to the mental health system to be students alongside people who use mental health services, thus addressing community stigma, and create routes into accessing community resources, such as mainstream educational and employment opportunities. In pursuit of stigma reduction and access to mainstream education, some Recovery Colleges are part of, or affiliated with, mainstream tertiary education providers.

Finally, Recovery Colleges provide a place for students to experience doing, being, becoming and belonging[212], and the latter two mechanisms create social inclusion outcomes. For example, the role of peer trainer is transformative for individuals in identifying their lived experience as an asset providing a route to employment rather than a deficit requiring treatment, and some students transition to paid or voluntary roles within the college[213].

Caregiving and parenting

A recent evidence synthesis on interventions to improve the social circumstances of people with mental health conditions did not find any systematic reviews or RCTs directly addressing the achievement or sustainment of intimate partner or family member roles, or maintenance of informal caring roles or custody of children[186].

Caregiving for adults as a valued social role has particular cultural importance in societies which emphasize the responsibility of members of younger generations to care for those who are older, such as those in which the influence of Confucianism is strong; and where access to formal services for support for frail or disabled people is limited. Research into the experience of family members of people with severe mental illness has shown that, while there are some negative aspects to this experience, there are also positive ones, including reciprocal caregiving[214]. It is, therefore, important that people with severe mental illness are not excluded from interventions to support caregivers, whether inadvertently or intentionally.

Available data suggest that around two-fifths of people with severe mental illness become parents, with a higher rate for women than for men. Similarly, a higher proportion of women have either their own children or stepchildren living with them[215]. There is some indication that these rates are increasing, likely due to increasing proportions of time living in the community and less time taking antipsychotics, which reduce fertility by increasing prolactin levels[216].

People with severe mental illness experience a range of difficulties as parents, due to symptoms, medication side effects, comorbid physical or substance use disorders, and internalized, interpersonal and structural stigma[217,218]. As a result, a range of recommendations have been made to create a system-wide, strengths-based, approach to supporting such parents, commonly referred to as family-focused practice. These include policy recommendations to reduce stigma and socioeconomic adversity and increase provision of trained staff; training to health and social care staff working with parents and children; monitoring, psychosocial support and respite care for children; and psychoeducation, practical and psychological support for parents[217]. Currently, implementation of family-focused practice is variable and challenging, not least because of the dual focus on adult and child family members required from service providers[219].

Overall, the evidence from a range of countries suggests the potential effectiveness of parenting programmes tailored to people with severe mental illness. However, a recent systematic review found that, while such interventions have been developed, only one small trial (N=50), from which no data could be extracted, has been published[220].

Romantic and intimate relationships

Intimate relationships are those involving romantic love, physical intimacy or sexual activity. These relationships are “a central aspect of being human”[221]. They are valued by most people with severe mental health problems as a key facilitator and indicator of recovery[85]. Yet, in clinical contexts, about two-thirds of these people are single[222,223]. They often report struggling to form and maintain romantic relationships[224]. For people with psychosis, satisfaction with their sexual life was the lowest rated of all life domains[225].

People with mental health problems commonly experience sexual stigma. Surveys of the public suggest that, for many people, mental illness is seen as a "dealbreaker", leading them to reject a potential romantic partner[80]. At the same time, people with mental health problems are viewed as more “sexually exploitable” than others[81], leaving them vulnerable to unwanted or upsetting sexual contact. People with mental health problems often absorb these attitudes and experience sexual stigma, e.g. believing that they are not viewed as acceptable romantic partners[223].

Relationship status satisfaction is inherently important, and is associated with higher well-being[226]. Romantic loneliness, more than family or social loneliness, is associated with suicidal behaviors[227]. Despite the importance of positive romantic/intimate relationships for many people who use mental health services, and their challenges in achieving them, these people often experience staff as uninterested in their problems in this area[87]. This has been described as the “institutional silencing of sexuality” in mental health care[228]. Mental health staff report numerous barriers and reservations to discussing people’s wishes and needs regarding romantic/intimate relationships, and a lack of resources or guidance to support them in this respect[88,229-232].

We identified two small pilot studies of group interventions in mental health settings to help people with severe mental illness develop intimate relationships[233,234]. Both involved only men, with first-episode psychosis, and used psychological approaches. One brief paper from 2006[235] described an innovative social relationship agency in a voluntary sector organization in England dedicated to helping people recovering from a mental illness find and sustain social relationships. The programme comprised three elements: regular social events; group training about how to initiate and manage friendships and romantic relationships; and individual coaching to discuss past or present relationships and offer practical suggestions about finding a partner. However, there was no formal evaluation, and the service is no longer running. There is, therefore, an absence of established models of support with needs for romantic/intimate relationships suitable for mental health care contexts, although fulfilling these relationships is a cornerstone of feeling socially included and belonging for many people.

Community engagement

A broad approach to community engagement is to consider aspects of citizenship, as exemplified by the Citizenship Project[236], developed in the US for people with severe mental illness, whose aim is to support personal recovery by fostering the five Rs of citizenship described above (i.e., roles, resources, responsibility, relationships and rights).

The intervention involves peer mentorship, a citizenship-based curriculum, and “valued role projects”. Peer mentors help participants identify and achieve goals, share strategies for supporting recovery, and advocate for participants’ access to important social determinants of health, such as employment, housing, social services and education. The citizenship-based curriculum is taught by a community advocate and supports problem solving, life skills acquisition, knowledge of community resources, and social network development. Specific classes focus on self-advocacy, housing, relationship building, and social integration. In valued role projects, people draw on their lived experience and curriculum to develop, lead and participate in projects aimed at supporting others in their community. Participating in this intervention was associated with a decrease in substance use and an increase in satisfaction with quality of life, employment, finances and social activity[236].

Turning to specific activities, engagement in community arts, volunteering or social groups offers critical opportunities for individuals to build social connections, enhance their coping strategies, and develop a sense of belonging. Participants in community programmes are often motivated by the opportunity to connect with others and the chance to experience positive emotions through shared activities[237].

For example, the “Art Lift” intervention, which offered ten weeks of art delivered by an artist in UK general practice, showed significant improvements in well-being among participants with mental health problems[238]. This intervention provided a safe space for creative expression through various art forms, such as painting, ceramics and poetry, facilitating the development of social networks and reducing feelings of isolation. However, this programme was not focusing on people with severe mental illness, and there are likely to be barriers – such as lack of motivation, opportunities, confidence, and social skills – to participation of these people in programmes of this kind. So, there is a need to develop specific projects that can be successfully implemented across a range of settings, and to identify enablers to participation and address the above-mentioned barriers[75,76].

There is some evidence[239] that group and facilitated nature-based interventions – including green exercise, therapeutic horticulture, and therapeutic offers such as forest bathing (i.e., immersing oneself in the forest environment through mindful, sensory engagement) – can improve mental health. While there is limited evidence for these interventions in people with severe mental illness, their focus on low-pressure, structured exposure to the natural environment makes them possible candidates for further development and testing.

Overall, this preliminary evidence suggests that social prescribing, arts-based and nature-based interventions, integrated into a structured multi-component programme, may be effective in fostering social inclusion in people with severe mental illness. Additional research is needed to refine their design and break down barriers such as low motivation and confidence, leading to more accessible and sustainable models for these people. Future studies should prioritize optimizing delivery models, evaluating feasibility and acceptability, and identifying the core mechanisms that can support sustained participation.

THE ROLE OF MENTAL HEALTH PROFESSIONALS

What can clinicians and other front-line practitioners do to support social inclusion? We identify example approaches relating to knowledge, attitudes and behavior.

At the knowledge level, clinicians can develop an understanding about the problem. Several UN reports[240-242] have identified rights violations as still frequent in mental health systems internationally. Global issues include institutionalization, isolation, segregation, and control through involuntary and compulsion-based approaches to management of people with mental health issues, especially those in crisis[243,244]. In relation to human rights legislation, the CRPD[95] was adopted in 2006, and has since been ratified by 185 of the 193 UN member states. The Convention comprises 50 articles describing the rights of persons with disabilities, including those arising from mental health issues, to independent living, education and employment, health, habilitation and rehabilitation, food, clothing, housing, justice, transportation, information technology, and voting. Articles 12 (being allowed to exercise legal capacity) and 14 (not being deprived of liberty unlawfully or arbitrarily) are particularly challenging to current mental health practice.

To address widespread non-compliance with CRPD at national level, the World Health Organization (WHO) developed in 2012 the QualityRights framework[245], which provides a range of resources to monitor and improve quality and respect for human rights. Of specific relevance to clinicians is the e-training toolkit published in 2022[246], which is intended for use by all mental health stakeholders, including clinicians. The training is available in multiple languages, and the toolkit comprises core and specialized modules. Core training covers human rights, legal capacity, recovery and freedom from coercion, violence and abuse. Specialized training covers recovery practices, strategies to end seclusion and restraint, and supported decision-making and advance planning.

The QualityRights approach has been implemented in many countries, including Afghanistan[247], Brazil[248], Czech Republic[249] and Lithuania[250]. There is emerging evidence from Ghana[251], Iceland[252] and India[164] that completing QualityRights e-training leads to beneficial staff attitudinal shifts. Integration with the World Psychiatric Association (WPA) programme on implementing alternatives to coercion in mental health care is underway[253]. In India, a pragmatic trial, involving implementation of QualityRights at six public mental health services, showed that, over a 12-month period, the quality of the performance of those services receiving the QualityRights intervention improved significantly. The mental health professionals at the sites showed substantially improved attitudes towards service users, and these users reported feeling significantly more empowered, and satisfied with the services offered. Caregivers at the intervention services also reported a moderately reduced burden of care[164].

At the attitude level, clinicians can develop an orientation towards supporting people's personal recovery (i.e., living a meaningful life in the context of mental illness)[153,254]. An international consensus has emerged about orienting mental health systems towards personal recovery and associated values such as rights-based and person-centred care. This orientation is now recommended by national policies in many countries, for example Australia[255], Canada[256], Hong Kong[257], India[258] and the UK[259], as well as in multinational guidance[260-262]. Cultural adaptations of the concept of personal recovery have been investigated globally, for example in Brazil[263], Japan[264], Poland[265], Spain[266], South Africa[267] and Taiwan[268].

A recovery orientation improves social inclusion: "People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services"[269]. Indeed, facility-based mental health care is on its own not equipped to meet social needs, such as addressing poverty and social isolation. It is, therefore, important to map resources that already exist in the community, and to maximize their accessibility by people with severe mental illness, also by establishing good working relationships with key people in the relevant sectors[261].

The impact of a recovery orientation on psychiatric professional practice and education has been explored in Austria[270], New Zealand[271], the UK[272] and the US[273]. Implementation approaches – and transformations from traditional practice – identified in systematic and umbrella reviews[274-276] include developing an organizational commitment to recovery[277], centering organizational culture around lived experience[278], facilitating access to community-based participatory arts[279] and leisure activities[280], supporting the social relationships which drive recovery[281], and political engagement to address structural discrimination[282].

At the behavior level, an important approach to improving social inclusion is focusing on decision-making style in clinical practice. A 2023 umbrella review found that decision support tools addressing social inclusion (e.g., social prescribing, work, lifestyle, housing, social/leisure activities) are needed, since most existing decision aids focus on psychopharmacological treatment[283]. One exception to this is the CORAL decision aid regarding disclosure of a mental illness in the employment context, relating to either current or potential future employment[11].

A promising development is peer-facilitated decision-making, in which peer support workers assist with decision-making as part of their wider role[284]. Peer support workers are oriented towards community engagement and integration, being well-placed to support social inclusion goal-setting and goal-striving.

PEER ROLES

Peers are a new resource emerging internationally to support social inclusion. A peer is someone with direct, first-hand past or present experience of an issue[285]. In a mental health context, a peer will typically have personal experience of mental health issues, whether formally diagnosed or not, and/or using mental health services.

This lived experience provides one type of knowledge. Other types of knowledge arise from loved, labored or learned experience[286]. Loved experience emerges from a role as a carer, family member, friend or colleague of a person with mental illness. In mental health, sometimes the term “peer” is also used to include loved experience. Labored experience is gained through work roles, such as clinician, police officer or teacher. Learned experience is obtained through researching or studying mental health and associated systems.

These four types of knowledge are not distinct. Many clinicians and researchers have a dual identity of both labored/learned and lived/loved experience[287]. For example, a national survey in the UK found that 40% of clinicians also have lived experience, and 75% also have loved experience[288]. The integration and use of this lived and loved experience within clinical practice can be challenging[289,290]. However, therapist self-disclosure supports recovery[291,292], and decision-making frameworks for staff with dual identity are emerging[293].

A recovery orientation tends to emphasize loved and especially lived experience. One benefit of this re-orientation is an increased emphasis on social inclusion. Indeed, there is a growing body of evidence showing a positive impact on social inclusion for people receiving peer support, including increased social functioning[294], higher satisfaction with family life and sense of community belonging[295], improved social network support[296], and stronger community integration[297]. The peer support worker also benefits: an umbrella review found that this role provides a route back into employment and improved social inclusion for the worker[298].

The Indian state of Gujarat used the WHO’s framework[245] to bring reform of mental health services since 2014-2016. One of the key developments was to introduce peer support volunteers in these systems to practice a recovery-oriented approach. These were people with lived experience of severe mental health conditions seeking care and treatment at the six intervention sites, volunteering part-time to support other persons with lived experience to fill out their recovery plans, and to organize and conduct monthly peer group meetings. One of the significant policy shifts towards sustaining this project was the provision of resources by the government of Gujarat since June 2016. The current funding provides for 35 peer support volunteers with a plan to increase their numbers over time[299].

One other model of peer support that promises to be acceptable, feasible and scalable comes from rural India[300]. In this model, called *Atmiyata* (which means shared compassion and empathy in local language), key members of the communities are trained to raise awareness on social issues impacting mental health by "narrow-casting" four 10-min films on commonly experienced social issues in the community (unemployment, family conflict, domestic violence, and alcohol dependence); refer people with severe mental health conditions to the public health system; and facilitate access to social entitlements.

Despite the growing interest in peer support, several challenges remain for integrating this support within formal health systems and for it to be seen as a legitimate intervention. In a primarily biomedical model, where people with lived experience have the least power, a peer support intervention requires an ecosystem change to a rights-based and recovery-oriented perspective. Further challenges are the need to develop peer support models that are co-designed with the communities, that really follow peer support principles in spirit and practice, that are evaluated for their effectiveness, and that have sustained funding pathways.

ADVOCACY

Advocacy has long been recognized internationally as a central component of mental health policy[301]. With a view to social inclusion, it is important to distinguish between advocacy which is part of the role of health and social work professionals[302], and the designated role of a patient advocate provided independently[303].

Taking the former, the potential impact that physicians' advocacy can have in reducing discrimination[304] has been acknowledged, agreeing that professionals could champion much needed structural changes through health care quality improvement and development of new policies. Mental health professionals can highlight service users' barriers to seeking and engaging with treatment, obstacles to rehabilitation due to discrimination in employment and within social networks, reluctance to pursue economic and social opportunities due to the anticipation of discrimination, and negative self-evaluation due to internalized stigma[305].

In other fields of medicine, especially primary care, there is an increasing focus on physicians' social accountability and advocacy. Several North American organizations have expressed a pressing need for advocacy training in medical education[306]. The Royal College of Physicians and Surgeons of Canada published a Physician Competency Framework, introducing health advocacy as one of six main competencies. The role of health advocate was described as "to determine and understand needs, speak on behalf of others when required, and support the mobilization of resources to effect change" [307]. These competencies have been adopted for psychiatry training in several other countries, such as for instance Ethiopia[308], where psychiatrists are likely to be called upon to develop policy, services and training, and to join with service users to advocate for better services.

Across many countries in the Global North, including the UK and Ireland[309], New Zealand, Australia and Canada[310], advocacy is also provided independently from statutory and mental health services, an approach identified as a foundational principle. Independent advocacy has been characterized by its potential to empower people through social inclusion, equality and social justice[311]. Moreover, the emphasis on advocacy's independence has been to mitigate against the potential for conflicts of interests, as the best interests of health professionals will not always align with those of service users[303].

Other forms of advocacy have a role in fostering social inclusion[312]. Citizen advocacy is centred on the involvement of unpaid volunteers trying to ensure that the voice of vulnerable people is heard. Peer advocacy involves somebody with lived experience functioning as an advocate by virtue of sharing a similar experience. Collective advocacy can include lobbying for improved access to mental health services, housing, work, education, and basic resources. Research documents the role of mental health service user organizations involved in collective forms of advocacy, as well as the precarity of this work due to resource limitations[312].

When considering the role of advocacy, understanding how culture can influence expectations and activities is part of developing a stronger evidence base. In a recent review[313], drawing mainly on collective advocacy, it was found that, within the Argentinian context, civic participation was a central part of belonging and identity, offering a fertile ground for involvement in mental health activism. Similar facilitators to involvement in mental health advocacy were noticed in South Africa, in relationship to the Treatment Action Campaign. These cultural conditions were found to contrast with the situation in Ethiopia, where civic participation is less common, making it challenging for advocates to negotiate the terrain and influence change.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

At the structural level, changes to discriminatory laws and implementation of equality legislation that includes people with mental illness have been discussed above. Structural level discrimination can in addition be addressed through interventions targeted to key occupational groups with the aim of creating organizational change. This includes both groups who have societal influence such as media professionals, and groups with professional contact with people with severe mental illness, such as health care, emergency service and criminal justice professionals. Finally, interventions can be aimed at the general population.

Media professionals

Mass communication sources, including the news media, provide fundamental frameworks through which most people come to perceive and understand the contemporary world. When mass media frame a group in a negative light, this propagates prejudice and discrimination. Media often reinforce common stereotypes of people with severe mental illness by providing a negative image of such people, who are labelled as dangerous or unpredictable[314-316]. Hence, whether intentionally or not, they may become social structures for perpetuating stigma[317].

Media professionals have therefore been a target group for behavior change interventions, most commonly the provision of guidelines on reporting, with or without monitoring to allow media outlets to be held accountable when guidelines have not been followed[318]. Other interventions have comprised contact-based education for journalists and journalism students.

Given the effectiveness of guidelines for reporting on suicide[319], and of contact-based education for stigma reduction among other groups[190], these approaches are promising and worth considering, though a systematic review of research on such interventions found limitations with respect to small sample sizes and short-term follow-ups[318].

Health professionals

A recent umbrella review[320] found that 68 reviews have been published since 1994 on stigma reduction interventions among health care staff and students. These focused on pre-qualifying stigma reduction programs for trainees, such as nursing and medical students, and in-service programs for qualified staff. More recent reviews have covered community pharmacy staff and students[321], and physiotherapy professionals and students[322], reflecting the recognition that stigma reduction is important for the provision of good quality care by all professionals. The stigma-related outcomes included changes in knowledge, attitudes, and clinical skills, as well as clinical confidence and self-efficacy[323,324]. Six meta-analyses reported small to medium effect sizes in improved attitudes; a range in effects on knowledge from negligible to large; and medium to large effects sizes in clinical skills[325-330].

A consistent finding is that interventions for health care professionals are more effective when tailored to the professionals' clinical setting and training requirements, for instance by covering specific diagnoses or providing tailor-made contact interventions[331]. Another is that the evidence for improving attitudes is greater for students in clinical settings where patients demonstrated recovery[332]. Two reviews suggested that interventions should be repeated regularly to sustain changes over time[330,333]. Many reviews recommend including people with lived experience in the design and evaluation of stigma interventions, in addition to providing contact through live or filmed recovery testimonials[334,335]. Some studies reported that both live and filmed contact were more often associated with better outcomes on stigma-related knowledge and attitudes than were educational interventions alone[326] or interventions with only one form of contact[336].

Two reviews focused on e-interventions for professionals, both reporting improved knowledge and attitudes, more humane treatment of service users, and reduced use of coercive methods[337,338]. Fully online interventions are effective at stigma reduction when they are multi-component, including educational tutorials, case-based instruction, and practice-based learning[337]. Internet-based anti-stigma campaigns have also been reported to reduce stigmatizing attitudes among health care staff[339].

The use of digital interventions and simulations – e.g., “serious games” or standardized role plays with actors or virtual patients – has increased in part due to COVID-19 pandemic restrictions. In all the studies reviewed, there was a benefit of simulations on stigma reduction[328,339-342]. A meta-analysis showed a small to medium effect size on learners’ attitudes, and a large effect size on clinical skills at immediate follow-up for simulation interventions, as well as sustained benefits three months later[328]. Another review reported that staff empathy improved with narratives of students’ personal experiences, exposure to individuals with lived experience, and reflective sessions, but did not improve with simulations, suggesting that direct contact and practice-based components are necessary for more positive effects on stigma reduction[343]. Similarly, the authors of a review on virtual reality interventions for health care and other students recommended that, while these have some potential, they should not be used in isolation and instead be combined with direct contact and education[344].

Few such studies have been conducted in LMICs[345-347], with China being the most frequently represented middle-income country[326,332,348]. It is clear that greater emphasis is needed for long-term collaborations between LMICs and high-income countries to pool resources and data[347]; assess the sustainability of impacts or effectiveness[339]; and develop cultural adaptations of the anti-stigma programs[347,349]. A further key challenge is that not all studies have used well-adapted outcome measures for stigma and discrimination, particularly in LMIC settings[345,346,350-353]. Researchers recommend more mixed methods with qualitative components[334]. Cost-effectiveness was also a common research gap[334,347,354], as were meta-analyses[334,354].

Stigma reduction interventions aimed at health professionals rarely address issues such as access of people with severe mental illness to screening for and management of physical health conditions. However, health professionals have a key role in preventing and addressing discrimination of these people regarding physical health care.

For instance, one contributor to poorer survival rates of people with severe mental illness after cancer diagnosis is unequal access to cancer screening[355,356]. A Western Australia data linkage study found that these people are more likely to present with metastases at diagnosis than the general population. This and other studies have found that these patients are less likely to get surgery and radiotherapy, and receive fewer chemotherapy sessions[357]. Among women, delays in help-seeking are particularly problematic, because of their increased risk of invasive cervical cancer, due to the higher prevalence of risk factors such as sexual abuse and risky sexual behavior. As routine cancer screening becomes more widespread, programmes to ensure its equitable implementation in people with severe mental illness are needed, requiring collaboration among mental health, primary care and radiology professionals[358].

A review of cancer screening, prevention and treatment[359] identified three factors which may play a role in reduced rates of oncology treatment uptake in people with severe mental illness: fragmented health services (primary, oncology and mental health care), health professionals' stigmatizing attitudes and behavior, and diagnostic overshadowing (i.e., the attribution of symptoms to the mental condition, which may delay appropriate diagnosis and treatment)[360].

Strategies to promote equitable access to and uptake of effective screening and early treatment of physical health conditions in people with severe mental illness are key priorities, and should make use of existing evidence such as that on informed choice tools[361] and implementation science[362]. Prejudicial assumptions by health professionals concerning, for instance, non-attendance at appointments or poor adherence to treatment[363] should be acknowledged as forms of discrimination and become the target of specific anti-stigma interventions.

Mental health professionals

While some evidence on mental health service users' experiences of discrimination[364,365] suggests mental health professionals as a target for stigma reduction intervention, any such intervention needs also to take into consideration these professionals' potential role in helping service users respond to discrimination, or acting in other ways as an anti-stigma change agent[366]. For example, qualitative interviews of a sample of the CORAL intervention group showed that many participants wanted to discuss their decision with a mental health professional in conjunction with working through the decision aid[367].

A 2024 systematic review[368] of the feasibility and effectiveness of training for health professionals in anti-stigma competency or related skills retrieved 39 studies, four of which reported interventions for mental health care professionals[305,369-371]. Program content varied:

some covered mainly interpersonal stigma reduction, others focused on social determinants of health, and some included advocacy at the structural level. While there was some evidence of effectiveness, it proved difficult to compare effectiveness across programmes, given the wide variety in content, duration, teaching methods, and outcome measures. Most studies were carried out in high-income countries, making it difficult to assess feasibility for LMICs. The authors concluded that, to maximize its relevance to the communities served, any intervention for mental health care professionals needs to link to the professionals' roles; be developed following a situational analysis; and include local people with lived experience of mental health problems in the delivery. Training should use interactive delivery methods, and evaluation should examine behavioral change.

Following this review, members of the INDIGO Partnership research team developed Responding to Experienced and Anticipated Discrimination training for health professionals working in mental health services (READ-MH)[12] in China, India, Ethiopia, Nepal and Tunisia. A cultural adaptation matrix was applied to create site-specific content relevant to the socio-cultural context, with specific examples of adaptation to each site. Delivery methods included facilitated group discussions and testimony from an expert by experience, and didactic content. Evaluation used a knowledge quiz tailored to the course content; a measure of attitudes to addressing stigma as part of one's professional role; and an objective structured clinical examination comprising a simulated mental health service user asking for advice on disclosure of his mental illness in the context of a potential marriage, to assess skills in responding to anticipated discrimination. Statistical analysis of the results is currently underway. However, qualitative feedback from each site suggests a positive impact on subsequent practice.

Criminal justice professionals

Criminal justice professionals are another key group for stigma reduction interventions. The deinstitutionalization of mental health services has led to a significant increase in contact between these officers and people with mental illness when they are unwell or are victims of crime.

A recent review[372] focused on training correctional staff (probation, parole and custodial officers). Most interventions were educational, with one including contact-based elements. A meta-analysis of six studies found a small positive effect on stigmatizing attitudes.

General population

While many countries or regions within countries have conducted, or are currently conducting, population-level anti-stigma programmes, only some have evaluated their impact on stigma towards people with severe mental illness.

Initiatives to promote awareness of and reduce stigma and discrimination against people with schizophrenia include the WPA's Open the Doors programme[373]. This was launched in 1998. Local action groups were set up in 20 countries across Africa, Europe, North and South America, and Asia. However, evaluations published in the academic literature are sparse. We found one from Germany[373], where surveys were undertaken in intervention and control cities before and after the interventions, which mainly comprised workshops for media professionals and panel discussions at public events. The evaluation found improvements in intervention cities, in terms of reduced desire for social distance in relation to transient social relationships but not closer relationships, while in control cities there was no change.

In England, the Time to Change stigma reduction programme (2008-2021) comprised social marketing, intergroup contact events, and work with employers and several target groups[374]. It covered both common and severe mental illness, and the evaluation designed for it just asked about mental illness in general[375]. However, vignettes of people with depression and schizophrenia were used in a separate survey carried out in 2007 and 2015 as part of the British Social Attitudes Surveys, conducted by the National Centre for Social Research. In 2023, two years after the end of the programme, the same vignettes were added to a repeat of the evaluation survey[376], so that both measures using general terms (mental illness or mental health problems) and measures using vignettes of people with depression and schizophrenia could be compared.

The stigma measures using questions about mental illness or mental health problems in general showed an increase in stigma between 2019 and 2023, following the improvements seen between 2008 and 2019, such that, although attitudes were still more positive since 2008, stigma-related knowledge and willingness to interact began to decline before the end of the programme and were finally the same as in 2009. In contrast, the questions based on vignettes of men with depression or schizophrenia showed reduced desire for social distance since 2007. This latter finding may reflect a more lasting impact of the programme, which promoted supportive contact with family, friends and colleagues experiencing a mental health problem[377]. Vignettes about an individual create a sense of familiarity and hence may generate more empathy. In contrast, the responses to the questions about social distance from anyone with a mental illness may reflect a greater desire to avoid others who are unknown, which is consistent with the decline in support for community-based care[376].

Internalized stigma

Internalized stigma, or self-stigma, can occur because of awareness and endorsement of stereotypes by labelled people. This phenomenon is common, reflecting implicit attitudes learned before diagnosis[378], public stigma awareness, and discrimination experiences[379]. It hinders social inclusion, due to avoidance of social and economic opportunities, and interferes with treatment engagement[380]. It is associated with lower self-esteem[381], self-efficacy[382], hope[383] and empowerment[384], and poorer functional[385] and clinical recovery[386].

A 2015 review[387] identified four interventions for which there is evidence of effectiveness with respect to some outcomes of interest. Psychoeducation aims to increase and apply knowledge using critical thinking to reject stereotypes[388]. Narrative methods, such as Photovoice[389] (taking photographs, in this case to help express the impacts of stigma and facilitate group discussion on how these impacts can be overcome) and narrative enhancement and cognitive therapy (NECT)[390], help people to make sense and create meaning from past experiences and to perceive the self as an active agent. Behavioral decision-making[391] uses tools and experiences to increase hope, empowerment and action directed at one’s goals and according to one’s values. Cognitive techniques are used to challenge and replace self-stigmatizing thoughts and beliefs[392].

Since that review, a study has used intergroup contact among young people with and without experience of a mental health problem to address internalized stigma, with promising results[393]. Intergroup contact has a good evidence base as a means to reduce prejudice between groups with a history of conflict[394].

Complaints to organizations have been effective in leading to changes in stigmatizing behavior. UK examples include complaints against the coverage of a well-known former boxer’s psychiatric inpatient admission in 2003, and the marketing of a “mental patient” Halloween costume in 2013[395]. People with severe mental illness may also wish to complain to services about discriminatory decisions[396].

A recent umbrella review found 34 reviews of interventions for self-stigma, all published between 2012 and 2024[397]. In general, the reviews included studies which reported either an improvement in self-stigma, or in a similar outcome such as stigma stress or self-efficacy. Two reviews with meta-analysis found that the improvements in self-stigma became non-significant over time[398,399], with two exceptions: NECT[400] and the Honest, Open, Proud (HOP) intervention[401,402] (a three-session group programme usually run by pairs of trained leaders with lived experience of mental illness, focusing on self-disclosure).

Differentiation of interventions was recommended for groups with different needs, such as people experiencing intersectional stigma related to gender, ethnicity or employment status[398]. Only two reviews focused on LMICs, finding positive effects of psychoeducation on self-stigma, self-prejudice, and coping with stigma.

Most self-stigma interventions are delivered to groups, a barrier for people unwilling to disclose a mental health condition. There are also limitations to individual cognitive and behavioral therapy, which has been criticized for pathologizing an understandable response to awareness of public stigma and experiences of discrimination[403]. Preference may be given to interventions that are widely accessible, such as psychoeducation[404,405]; do not require group attendance, such as peer support[406,407] or digital interventions[408]; and target help-seeking[409]. A clear learning is the need to assess interventions delivered outside health care, such as social marketing campaigns, which aim to reduce stigma from its sources, but may also reduce self-stigma.

RECOMMENDATIONS FOR ACTION

A common reason for structural exclusion, especially at the level of legislation and policy, is the assumption that people with severe mental illness lack decision-making capacity at all times or in relation to all decisions. Another repeated finding is that programmes which aim to either reduce mental illness-related social exclusion through stigma reduction, or to increase social inclusion, tend to neglect severe mental illness. Stigma reduction programmes without a focus on diagnoses imply a focus on common mental disorders through communication that "we all have mental health" or through messages about the prevalence of mental health problems, while those that do focus on one or more diagnoses most commonly do so on depression. We suggest that a combination of both is the most problematic, by appearing to include all illnesses but then only covering some. Evidence for this comes from qualitative interviews of people using the "Every Mind Matters" web resource launched in England in 2019. Fewer mental health problems were covered due to diversion of funding during the COVID-19 pandemic, causing disappointment among some users of the site with more severe problems[410].

It seems that, where services exist for people with severe mental illness, this creates the risk that these services are expected to do everything to promote social inclusion for everyone with a severe mental illness. These people are then excluded from services and opportunities in the community from which they may benefit[411]. The goal of social inclusion requires that mainstream services and opportunities are fully accessible to people with severe mental illness, and that mental health professionals make full use of them.

On the other hand, many people with severe mental illness face particular challenges, for example in relation to loneliness and valued social roles such as paid employment and parenting, for which tailored programmes are needed, with input from both mental health professionals and people with their own lived experience. The recommendations below aim to maximize inclusion by striking a balance between mainstream and tailored programmes.

1. Amend legislation and policies based on assumptions about mental capacity

Extrapolating from the above-mentioned UK and EU examples, it seems possible that there are many pieces of legislation and many policies which exclude people with current or previous severe mental illness from taking up specific roles, carrying out forms of social participation, or making decisions about their own lives. This discriminatory situation arises when legislation and policies are based on assumptions that having lost decision-making capacity at one time, this cannot be recovered; or that, because decision-making capacity has been shown to be impaired in relation to one type of decision (such as health care), it is impaired in relation to other types of decision, such as voting preference or decisions about personal finance.

Our first recommendation is that governments scrutinize all legislation that potentially contains discriminatory clauses such as these, and amend it to eliminate discrimination based on mental illness. As mental health legislation itself may contain discriminatory aspects[412], we recommend review of this legislation using established frameworks[245], with the aim of reform where needed to promote autonomy and choice, supported by advocacy and shared decision-making processes.

2. Decriminalize suicide, attempted suicide, and use and possession of substances for personal use

Legislation that criminalizes suicide in line with religious prohibition is ineffective[98] and harmful. In countries where suicide is still illegal, civil society organizations, such as health professional representatives, charities and patient and carer groups, can draw hope and learn from the recent successful social and mass media campaign “Patients not Criminals” in Pakistan, which involved engagement of policy makers, media and mental health professionals, and speaking out by those with lived experience of the impact of this legislation[413].

Similarly, focusing on harm reduction and treatment for substance use disorders instead of criminalizing possession of drugs for personal use would benefit the significant proportions of people with severe mental illness who have comorbid substance use problems[414].

3. Improve the evidence base for the effectiveness, cost-effectiveness and implementation outcomes of interventions aimed to foster social inclusion

This review has highlighted limited evidence for effectiveness, cost-effectiveness and implementation outcomes of interventions aimed to foster social inclusion for people with severe mental illness in several areas.

In relation to education, in addition to the evidence of Recovery Colleges' effectiveness in relation to broad aspects of social inclusion such as social network size and vocational outcomes[415], we recommend research on these Colleges' effectiveness as an adult education model in facilitating access to mainstream education. As an intervention more tailored than Recovery Colleges to help people with severe mental illness to access education, supported education has been the subject of a few trials, but the evidence base is much less than for supported employment[186]. As the success of the latter is for many people limited to gaining low-paid, low-skilled work, we recommend more focus on interventions such as supported education which may open up more career choices. Further, education may help people develop other skills important in facilitating social inclusion, from literacy to social skills.

Regarding tailored interventions to support intimate relationships, the case has been established that these are needed, and a small number of trials of some interventions are now underway. There is likewise a case for the development and evaluation of parenting programmes tailored for people with severe mental illness with children of each age range. It appears that some programmes have been developed, but neither usable trial evidence nor evidence from other controlled study designs is available[220]. Intervention components that may influence feasibility, acceptability, maintenance of fidelity and sustainability should be identified during the adaptation process to maximize future equitable implementation.

4. Enable staff of mental health and other services to work in ways that maximize access to local resources which promote social inclusion

Several factors hinder access to community assets to promote social inclusion by people with severe mental illness. Within mental health services, there is an under-emphasis on the importance of maintaining knowledge of these resources and good working relationships with relevant providers during training. This lack of emphasis may reflect prioritization of treatment provision and risk assessment in those services. Within community assets, barriers limiting openness to working with mental health services include stigma, lack of confidence in dealing with people with severe mental illness, and low capacity. At the structural level, historically poor relationships between the statutory and voluntary sector in some countries and insecure funding for some community resources hinder development of partnership working.

Resource mapping[416] of community assets is one step in the process required to ensure effective access to these assets by people with severe mental illness. The mapping process must be repeated regularly, as new organizations start and others are defunded or change their mission. Mental health professionals must form and maintain good working relationships with community service providers, such that they transfer skills and knowledge and advocate for their clients while avoiding either allowing stigma to go unaddressed or making counterproductive accusations of stigma. They must also work with their clients in ways that increase their self-confidence, for example through shared decision-making.

Community service providers must consider their obligations under equality legislation covering people with disabilities, including those with additional, intersecting characteristics that can lead to even more marginalization, and work to ensure equity. Gaps in services identified through mapping that result in geographical variations in access must be flagged to relevant organizations. Research is needed on services where mental health and other community services work together well, to identify strategies for successful spread and sustainment.

5. Engage with employers to design jobs with more flexibility

The flexibility of the agrarian sector promotes employment for people with severe mental illness, whose symptomatic and functional outcomes are better in rural than in urban areas, despite less access to health care. As urbanization continues across the world, it poses a significant threat to many of those currently benefiting from agrarian employment, and an enormous challenge to all those with an interest in employment for people with severe mental illness.

Although supported employment is now widely provided in many countries and heavily promoted by those involved in its development and evaluation, its implementation is unlikely to make it universally available at all times during the life of someone with severe mental illness. Further, this approach has limitations in terms of who benefits and where[417], and the types of jobs that recipients gain, which in some economies are scarce[178], and in other economies are available but are low paid.

We recommend that people with lived experience, mental health professionals and employer representatives collaborate with the aim of identifying, implementing and monitoring the types of workplace accommodations needed for people with severe mental illness to work in mainstream employment. National policies to mandate and/or incentivize this process are needed, followed if needed by litigation in response to implementation failure. We further recommend that vocational rehabilitation specialists and Recovery Colleges provide training and teaching on self-employment.

6. Include severe mental illness explicitly in stigma reduction programmes and target structural along with interpersonal discrimination

The association in the public perception between psychosis and violence may make stigma reduction harder in relation to this group. There is some evidence for this based on analysis of newspaper coverage of mental illness over the course of England's Time to Change stigma reduction programme. While the probability of articles about other diagnoses being coded as stigmatizing fell over time, this was not the case for articles including the term schizophrenia, for which it was unchanged in 2016 and 2019 compared to 2008 and 2009[418].

Ignoring the greater difficulty in reducing stigma against this group risks exacerbating existing differences in levels of stigma between those with common versus severe mental illness[419], and potentially even increasing the level of stigma towards people with severe mental illness through "othering", since excluding psychosis or other less common conditions from campaign content may imply that stigma reduction is somehow not merited in relation to these groups.

Just as it is all too easy to focus on common mental disorders when delivering stigma reduction programmes, it is also tempting to focus on interpersonal stigma reduction at the expense of structural discrimination. The latter is more politically challenging, especially if government funders proscribe structural discrimination targets, while the evidence base for contact-based education for interpersonal stigma reduction means that it is easy to make the case for focusing on this[190].

Therefore, we recommend that people with severe mental illness be consulted about their experiences of exclusion across all life areas, and that priority targets are chosen accordingly. These priorities will vary by setting. For example, in low-resource communities where formal employment may be the exception, they will more likely include interventions to address the systematic exclusion of people with mental health conditions from community development programmes, livelihood opportunities, micro-finance schemes and other economic opportunities[190], as opposed to discrimination by employers.

7. Support the development of conceptual competencies in the mental health workforce

Explanatory frameworks impact on support for social inclusion. Transitioning to a mental health system which is more diverse in this regard will involve changing the prevailing culture. A stronger emphasis on ontological and epistemological training within professional education would improve the foundational knowledge and attitudes needed for epistemic humility[174].

The development of demonstration sites which use a wider range of explanatory frameworks to support meaning-making would create immersive training opportunities for professionals, inform clinical innovation, and allow the benefits and harms of a decreased emphasis on clinical models to be evaluated[420]. Experience from settings where biomedical and other models (e.g. traditional medicine, faith and spiritual healers) are integrated can inform clinical practice.

CONCLUSIONS

In this review we identify strategies to increase social inclusion at the levels of national legislation, services providing mental health care, and other community assets. Gaps in research and provision in relation to loneliness and some valued social roles such as parenting and intimate relationships are at first glance surprising, and suggest their neglect at the expense of a focus on economic productivity through employment and on inpatient cost containment through consistent use of medication.

Foundational research is needed to develop interventions to support people with severe mental illness in fulfilling social roles that are critically important both for them and for their partners, relatives and carers. There is no research on support for women to make and maintain safe and satisfying intimate relationships, despite their increased vulnerability to domestic abuse and financial exploitation, and hardly any on interventions for men. Research to develop and evaluate such support should be part of suicide prevention strategies, due to the relatively stronger relationship between suicidality and romantic loneliness, as opposed to other types of loneliness. The key actors therefore include not just researchers and research commissioners, but also public health officials. Similarly, policy makers and professionals concerned with child welfare and development have an interest in the tailoring and evaluation of parenting interventions for people with severe mental illness.

A second focus should be on the equitable implementation of interventions with a sufficient evidence base, and de-implementation of interventions which are exclusionary. To be considered in this context are the above-mentioned needed legal changes: rescindment of discriminatory legislation, decriminalization of suicide and possession of drugs for personal use, and reforms of mental health legislation to promote autonomy and choice. The key actors in this area are therefore legislators and those who lobby them. Uptake of QualityRights training is a relatively straightforward step, while greater implementation of family interventions for psychosis continues to be a challenge to be brought to the attention of those experienced in or interested in implementation science[421,422].

A third group of interventions are those which require more tailoring to context and more ambition. IPS has been focused on increasing employment in low-paid, entry-level jobs. Supported education has been relatively neglected, as have other means to support people into self-employment, which in many countries is a more viable option. Similarly, interventions to avoid homelessness and destitution such as Housing First, with a strong but very context-dependent evidence base, require adaptation to different welfare and housing policy contexts, especially in LMICs, where intensive and specialist mental health support is not available.

Finally, there is a pressing need to evaluate services and interventions which have a strong theoretical basis and have become widespread in some countries in the absence of evaluation, in order to identify their key components, effectiveness and cost-effectiveness before encouraging further spread. Above we have discussed Recovery Colleges, which may be vulnerable to funding cuts if a better evidence base is not established. This includes not only studies of their effectiveness for people with severe mental illness, but also of their accessibility to this group following implementation. This requires service providers and researchers to co-produce the evidence base. It will frequently not be ethical to conduct RCTs of services already available, so researchers and funders will need to consider theory-based approaches and natural experiment designs.

The development and use of an evidence base for tailored interventions to be delivered within mental health services may be more straightforward than ensuring that people with severe mental illness gain and maintain equity in relation to use of other community assets, whether for physical health care, leisure or education, as these require inter-agency working and agreement about the responsibilities of each. Our recommendations cover both the more straightforward and the more difficult actions, in the hope that those suited to addressing each will respond.

ACKNOWLEDGEMENTS

M. Slade acknowledges support from the UK National Institute for Health and Care Research (NIHR) Nottingham Biomedical Research Centre. M. Slade, C. Henderson and Y. Kotera acknowledge funding from a NIHR Programme Grant for Applied Research (no. NIHR200605). A. Salla and C. Henderson are funded by an NIHR Policy Research Programme grant (no. NIHR205233). C. Henderson is also funded by a Maudsley Charity Living Well With Psychosis grant (no. 2946). P. Coventry is supported by a NIHR Public Health Research grant (no. NIHR157698), a Programme Development Grant (no. NIHR206939), and Programme Grants for Applied Research (nos. RP-PG-1016-20003 and NIHR200607) and Health and Social Care Delivery Research (no. NIHR151887); and by NIHR Applied Research Collaboration Yorkshire & Humber. The views expressed here are those of the authors and not necessarily those of the funders. The authors would like to thank M. Rashed for providing background information during the drafting of the manuscript.

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