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COMMENTARY

Two pressing needs: to measure social integration and to re-orient mental health services towards social integration

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Social integration is now regarded as an important outcome of mental health care. It is achieved through the provision of psychosocial interventions, for example, by long-term community-based residential care or supported employment programmes. These interventions help to avoid negative outcomes for people with severe mental disorders, such as suicide, poverty, human rights violations and incarceration, which are all linked to social marginalization and lack of support and care.

However, even if it is generally accepted that psychosocial interventions contribute to facilitate the social integration, the evidence about the effectiveness of those interventions remain largely insufficient.

In 2010, WHO launched the mhGAP Intervention 'Guide for mental, neurological and substance use disorders in non-specialized health settings' (World Health Organization, 2010). The guide was developed following a rigorous process that included a systematic review of the available evidence for mental health interventions. The review reinforced the fact that there were far fewer studies examining the effectiveness of psychosocial interventions and rehabilitation programmes compared with pharmacological interventions. In addition, the former tended to be of lower quality. It is, thus, obvious that in order to improve the evidence-base around psychosocial and rehabilitation programmes, we need to better define the concept of social integration and devise more reliable ways to measure it.

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The article by Baumgartner and Susser examines the notion of social integration and its measurement, and calls for the development of measures for cross-cultural use. Unquestionably, the authors have identified an important issue.

Indeed, the definition of social integration remains rather vague among psychiatrists, and even more so when mental health workers come from different disciplinary perspectives: the same word is used with different meanings and with a different emphasis. For example, Berger-Schmitt and Noll from the German Centre for Survey Research and Methodology on Social Indicator Development (Berger-Schmitt & Noll, 2000) consider that *social integration* has to do with the dynamics between social exclusion and social inclusion. Others emphasize *poverty* as the key element of poor social integration (Atkinson & Marlier, 2009). Ware *et al.* (2008), from the Harvard Department of Social Medicine, identify social integration with *quality of life*.

This article by Baumgartner and Susser provides a conceptual framework for social integration based on four perspectives: (i) the disability framework promoted by the WHO through the International Classification of Functioning, Disability and Health (ICF) and related disability assessment instruments; (ii) the US mental health service literature; (iii) Amartya Sen's notions of Capabilities and Commodities; and (iv) the notion of sub-communities as a potential framework for social inclusion of people with severe mental disorders.

These perspectives may be useful for a better articulation of the notion of social integration, but Baumgartner and Susser do not provide any rationale for adopting these four perspectives over others as a framework for defining social integration. Furthermore, they do not explain why the 'US mental health service literature' should become a reference to define the notion of social integration which, in their view, should have 'global' relevance.

When I read the article for the first time I felt reasonably satisfied, the issues raised were relevant and I fully agree with the authors for many of the suggested directions.

However, upon reading the article for a second time I felt like I was on the Titanic sinking with the orchestra continuing to play. What I mean is that the issues raised by the authors are relevant *provided* that we put aside the sinking of the boat: the 'pressing need' (as stated by the authors) is 'to better articulate and measure this outcome' (the social integration). However, is it not rather, to radically re-orient mental health services towards social integration as their desirable outcome?

The authors rightly state that global calls for adopting social integration as a key outcome have not been accompanied by efforts to put forward a clear framework for conceptualizing and measuring social integration. This is probably true, but what I find more alarming is the lack of implementation rather than the lack of evaluation.

First, the majority of mental health services around the world are dramatically insufficient from the point of view of resources (financial and human) and are not able to reach even a minimum standard of quality. The recently published WHO Atlas (World Health Organization, 2011) shows that 40% of countries of the world do not have a dedicated mental health policy and, among them, there is India, the second most populous country in the world. The median percentage of health expenditures dedicated to mental health is 0.5% in low-income countries and only 2.3 in upper-middle income countries. In 72% of countries, primary health care doctors have not received training in mental health within the last 5 years. The rate of mental health outpatient facilities per 100 000 population is 0.04 in low-income countries and only 1.05 in upper-middle income countries. The median rate of community residential facilities per 100 000 population is 0 in low-income countries, 0.005 in upper-middle income countries and 0.066 in high-income countries. In 57% of countries of the world, mental health services do not provide psychosocial interventions and even in Europe the percentage reached 41%. Most psychiatric beds, 62%, are still in mental hospitals, while only 21% are in general hospitals.

Clearly, these data show that social integration has not been adopted as a core mental health service goal in the majority of countries.

Second, a report of the European Committee for the prevention of torture and inhuman or degrading treatment or punishment (CPT) states that between 1990 and 2001 'several cases of deliberate ill-treatment of patients' and 'many serious cases of dysfunctions concerning staff, treatment, the use of seclusion and restraint as well as lack of adequate safeguards' were described during the visit to 78 European psychiatric establishments (Niveau, 2004). The list of articles, reports and documents denouncing systematic violations of human rights in psychiatric facilities come from all parts of the world including large countries, such as Russia (Lokshina *et al.* 2004) and China (Lu & Galli, 2002). Alem describes human rights violations and minimal psychiatric care in Africa, with particular reference to Ethiopia (Alem, 2000); in Mexico, Disability Rights International (DRI) and the *Comisión Mexicana de Defensa y Promoción de los Derechos Humanos* (CMDPDH) released a joint report detailing the human rights abuses perpetrated against children and adults with disabilities. Investigators found people with disabilities left permanently in restraints; the use of psychosurgery without consent; people detained for a lifetime in locked facilities and filthy and inhumane living conditions (Rosenthal *et al.* 2010). Serious and systematic cases of human rights violation have also been reported in many other countries around the world, including in Western European countries. For example, the French government announced in March 2012 that it is formally opposed to the practice of 'packing therapy', a so-called treatment for children diagnosed with Autism Spectrum Disorders, in an estimated 300 psychiatric and educational facilities across the country (Disability Rights International, 2012).

It is obvious that all the psychiatric services that systematically violate the human rights of the service users (and they are many, too many) do not place social integration at the centre of their preoccupations and strategies.

Third, the many psychiatric services that are sufficiently equipped in terms of human resources and technical skills and which are not violating the human rights of their users *do not necessarily promote social integration*. It is true that no specific data are yet available, but we do know that the biomedical paradigm pervades all of psychiatric care. The logic behind the biomedical paradigm is linear (damage to the central nervous system provokes a condition of illness, and the treatment aims at repairing this damage) and not contextual. Admittedly, the biomedical model is simple, reassuring and fast. The historical reasons for why psychiatrists are proud to be part of the scientific discourse are understandable: in the past, they were often excluded. However, the motivations leading to the hegemony of the biomedical model in the psychiatrists' practice should not prevent the adoption of a more comprehensive approach. Science has proven the complex interaction between genes, brain and environment.

The strong resistance of the psychiatric establishment to innovation in care delivery is probably the

major obstacle to putting social integration at the centre of goals pursued by mental health services. Recent events in Argentina illustrate the problem: a new innovative mental health law proposed by parliamentarians, public health experts, mental health professionals, users and family associations, human right advocates and with the technical support of the World Health Organization, was strongly opposed by the two local psychiatric associations (the Law was finally approved by overwhelming majority by the Argentinean Parliament).

In conclusion, I am concerned that only a minority of mental health services world-wide are offering a bio-psychosocial approach to their users. Thus, I am convinced that besides the timely efforts to better conceptualize and evaluate social integration, for which I congratulate the authors, psychiatry urgently needs to seriously address the fundamental resistance to introducing a biopsychosocial approach in the delivery of mental health care.

Conflict of interest

None.

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