Development of a ‘Social Inclusion Index’ to capture subjective and objective domains (Phase I)

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EXECUTIVE SUMMARY

- The project team for Phase I of the development of a social inclusion index consists of the following: Professor Peter Huxley, Dr Sherrill Evans, Maria Munroe (Swansea), Professor Martin Knapp, Dr Tanya Burchardt, Dr David McDaid, (LSE), Martin Webber (IoP).

- The phase I project was in four parts.
  (1) An update of the social exclusion and mental health review undertaken at LSE, and a parallel review of social inclusion and its measurement.
  (2) A review of existing measures, whether derived from the formal reviews above, web-searches, or personal contacts.
  (3) Nine concept mapping exercises, conducted with differently composed groups, including mental health service users, professionals, and members of the general population.
  (4) Review of the findings and this report by experts. One expert group consisted of the authors of the report, and the other of the NIMHE social inclusion research and evidence coalition.

- Individual members contributed variously to different aspects of the project and all contributed to this final report. All the authors acted as an expert group in the analysis and synthesis of the findings from the project, and in the completion of this report and the presentation of 21st December 2006. In addition, both our team and the other research team funded under Phase I were offered the opportunity to work with the NIMHE social inclusion research and evidence coalition, which we were happy to accept. Coalition members contributed to expert group discussions, reviewed this report and constituted one of the concept mapping groups.

- Clair Curran, Tania Burchardt, Martin Knapp and David McDaid undertook the original mental health and social exclusion review at LSE, and Tania Burchardt and David McDaid undertook an update of this review for the present project. In addition Dr Sherrill Evans and Professor Huxley undertook another literature review of social inclusion and its measurement for this project. Maria Munroe, with the assistance and supervision of Professor Huxley, Dr Evans and Martin Webber, conducted the concept mapping exercises.
FINDINGS

- The project started by updating the recent literature review looking at the links between social exclusion and mental ill-health undertaken at the Centre for Analysis of Social Exclusion and the PSSRU at the London School of Economics (Burchardt, Knapp et al) in which two broad schools of thought were identified. The first may be called a rights-based approach: social exclusion reflects the deprivation of rights as a member or a citizen of a particular group, community, society, or country. Rights-based conceptions of social inclusion may be particularly important in the context of mental health, since a denial of rights and/or access to the means to realise entitlements has historically been a feature of the treatment of people with mental illness. Conceptions of social inclusion based on participation are also important, however, especially where comparisons with the general population are sought.

- Social inclusion is widely agreed to be:
  
  - relative to a given society (place and time);
  - multi-dimensional (whether those dimensions are conceived in terms of rights or key activities);
  - dynamic (because inclusion is a process rather than a state);
  - and multi-layered (in the sense that its causes operate at individual, familial, communal, societal and even global levels).

- We identified two broad approaches to the measurement of social inclusion (a) social indicators of inclusion and (b) perceived inclusion measures.

- The reasons for wanting to use an index of inclusion are variable, and include policy, theory, practice, evaluation, research and ‘real world’ uses. It may be that one index fit for all of these purposes cannot be created, and it may be that the indicator approach is better for policy purposes and the perceived inclusion approach for clinical and ‘real world’ purposes.

- It may be that for other purposes some combination of both approaches might be valuable and acceptable, but this has not been tested to date.

- We found that there were several existing social indicators measurement exercises that might be used to produce a social indicator based measure of social inclusion. We cite the main candidates for this in the main report and in Appendix 3.
• Another option, (parallel to the suggestion of Levitas et al re an exclusion index) is that there should be a social inclusion module incorporated into a UK longitudinal household survey. The disadvantage of this is that household surveys may miss the most excluded groups.

• A further option is that an index might be garnered from existing UK social surveys, and Levitas et al identified the most promising ones for young people, older people and adults of working age. One disadvantage of this approach is that the questions are pre-determined and may not be the most fit for purpose.

• A disadvantage of all the indicator approaches is that it is often unclear why certain indicators have been chosen above others, by whom they were chosen and that the form and content of the questions used may not be acceptable to the respondents.

• On the basis of the evidence we have reviewed we suggest that any proposed social inclusion index should focus on the availability of opportunity to access material and other resources, and the subjective view of this availability. It should address the extent to which the person participates in these life activities, and also the person’s subjective perception of the value or benefit of these activities for themselves. It should also assess the degree to which the person wishes to have more or less or the same level or type of participation in each life domain, otherwise it is not possible to encompass the feelings of those who are satisfied with what might be a low level (personally and normatively) of activity through choice.

• There is no single, tested and sound measure of social inclusion that is an accepted standard measure. Measures of the component parts of a possible measure, such as access to material goods etc, and social and community participation, are available, but usually do not have adequate psychometrics, with the exception of the Van Brakel measure, and there are some reservations about its use. The instrument developed by Wilson et al, currently being applied in North Adelaide might prove to contain some useful scales, but the results have not been reported yet.

• We are therefore left with the need to create a new index, as suggested in the original Phase 2 proposal. We think that it is worthwhile attempting a combined approach, rather than leaving social indicator research to social scientists and leaving the perceived inclusion research to clinicians.

The implications for our Phase II proposal are:

• The psychometric testing of the instrument will follow the outline in our original proposal. However, there are some additional prior
steps that would be required in order to populate a measure with specific questions.

- First, on the assumption that the opportunity of access questions, and participation questions (and scaling) are those that are most likely to relate to existing indicator questions, it would be necessary to reach agreement about with indicator questions are the most fit for this purpose. Here, it would be important to work with existing indicator researchers to arrive at the best set, including their acceptability to excluded groups. One major purpose of this approach would be to show where a patient population is relative to the local or regional or national norms on the same items.

- Second, a similar process to determine the best and most acceptable forms of words (to excluded groups and in general) for the subjective questions would be needed in each of the domains where indicators have been selected. Both sets of questions could be cognitively appraised.

- Instrument testing would follow the original plan. However, we now have some alternative tested measures, with reasonable psychometric properties against which a new index could be compared for convergent and discriminant validity.

- Different forms of the measure may be required. There are two options; different measures for young people, people of working age and older people as in the NPI work; or a common core measure with additional questions relevant to these groups. The concept mapping exercise gives us a beginning in identifying the different age-related concerns. Self-rated versions could be tested against interview versions.

- Finally, in the interests of conceptual progress, we would suggest an experiment, possibly funded from other sources that would involve applying standard measures of the several related concepts referred to in the background section of this report, to a large population sample, across several localities, to see whether a latent analysis supports the discreteness of the constructs. This would also involve multi-level modelling to encompass the issues of individual and area level measurement. This would be something similar to the subjective measures paper we produced for the Journal of Nervous and Mental Diseases on subjective ratings (Priebe et al 1999).
1 INTRODUCTION

The project team for Phase 1 of the development of a social inclusion index consists of the following: Professor Peter Huxley, Dr Sherrill Evans (Swansea), Professor Martin Knapp, Dr Tanya Burchardt, Dr David McDaid, (LSE), Martin Webber and Maria Munroe (IoP).

The project was in four parts.

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2 CONCEPTUAL BACKGROUND

Social exclusion and inclusion

Social exclusion was not a widely used term in the UK until 1997, when the Labour government established a co-ordinating policy body called the Social Exclusion Unit (SEU 1998). The government itself has offered a wide view of social exclusion, defining it as:

"Those people who do not have the means, material or otherwise, to participate in social, economic political and cultural life” (Brennan et al 1999 p.4). Social exclusion focuses primarily on relational issues - inadequate social participation, lack of social integration and lack of power (Room, 1997). According to Berman and Phillips (2000) social exclusion manifests itself at both the national and community level. Inclusion in society is normatively defined, for example, as citizenship, having a job, home or financial security according to the norms of society. It also includes being part of, and identifying with, a community. In our heterogeneous society community may be a more relevant measure of 'inclusion' than a national identity, which may be more amorphous.

Researchers in the poverty tradition in Europe made the distinction between ‘poverty’ which they defined as a lack of resources, and ‘exclusion’, which was more comprehensive. It was suggested that social exclusion should be defined in terms of the failure of one or more of the following four systems of ‘integration’: the democratic and legal system which promotes civic integration; the labour market which promotes economic integration; the welfare state system promoting social integration; and the family and community system, which promotes interpersonal integration.

One’s sense of belonging in society depends on all four systems. Civic integration means being an equal citizen in a democratic system. Economic integration means having a job, having a valued economic function, being able to pay your way. Social integration means being able to avail oneself of the social services provided by the state. Interpersonal integration means having family and friends, neighbours and social networks to provide care and companionship and moral support when these are needed. All four systems are therefore important. In a way the four systems are complementary: when one or two are weak the others need to be strong. And the worst off are those for whom all systems have failed (Commins, 1993, p4).

Social exclusion can also be conceived of as a denial, or non-realization of citizenship rights – civil, political and social rights. The four major social systems referred to above, should, when working effectively, guarantee full citizenship. Steps towards the creation of social inclusion will therefore involve ensuring that the systems operate effectively, preventing the
exclusion of individuals and communities, with full citizenship as the result.

Social exclusion has been defined in the EU Joint Inclusion Report as “A process which ensures that those at risk of poverty and social exclusion gain the opportunities and resources necessary to participate fully in economic, social and cultural life and to enjoy a standard of living and well-being that is considered normal in the society in which they live. It ensures that they have greater participation in decision making which affects their lives and access to their fundamental rights (as defined in the Charter of Fundamental Rights of the European Union). Elsewhere (EU Commission Social Policy Agenda) the aim of the social inclusion policy in the EU is "to prevent and eradicate poverty and exclusion and promote the integration and participation of all into economic and social life.

As part of a recent literature review looking at the links between social exclusion and mental ill-health undertaken at the Centre for Analysis of Social Exclusion and the PSSRU at the London School of Economics (Burchardt, Knapp et al), two broad schools of thought were identified. The first may be called a rights-based approach: social exclusion reflects the deprivation of rights as a member or a citizen of a particular group, community, society, or country. This approach is strongly associated with the international literature on social inclusion (for example, Rodgers et al, 1995).

The second approach starts from the assumption that social inclusion is the opportunity to participate in key functions or activities of the society in question. This approach is a development of the traditional concerns of social science and especially social policy, with measuring poverty and multiple deprivation (Townsend, 1979; Gordon et al, 2000). Table 1 below combines Commins’ forms of integration with these two broad approaches, which, it could be argued are broadly similar to the concepts of ‘demos’ and ‘ethnos’ (Berman and Philips 2000; Delanty 1998; Huxley and Thornicroft 2002).

<table>
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<th>Table 1: Rights, participation and integration</th>
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<td>Rights (demos)</td>
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<td>Labour</td>
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<td>Welfare state</td>
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<td>Family – community</td>
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Rights-based conceptions of social inclusion may be particularly important in the context of mental health, since a denial of rights and/or access to the means to realise entitlements has historically been a feature of the treatment of people with mental illness. Conceptions of social inclusion based on participation are also important, however, especially where comparisons with the general population are sought. Some authors attempt to integrate the two approaches. For example, Room (1995), Abrahamson (1998), Kronauer (1998) and Littlewood (1999) argue that social exclusion is the reinforcement of accumulated social disadvantages through the denial of civil, social and economic rights. Reimer 2004 proposes that social inclusion & exclusion processes are rooted in four types of social relations: market (exchange & barter), bureaucratic (rational-legal), associative (common interest), & communal (complex reciprocity & shared identity).

As well as there being at least four systems of integration, there are also several levels at which they can be addressed, these are the individual level; family and close networks – perhaps the household level; local community/local employer/local leisure activity and availability; government policies and initiatives to promote personal and community integration; and the responses of wider society.

Despite divergent theoretical standpoints, there is considerable overlap between the definitions of inclusion, which have emerged over the last decade (Burchardt, Le Grand and Piachaud, 2002). According to Burchardt, Le Grand and Piachaud (2002) there are four aspects of social exclusion: consumption, where individuals do not have the capacity to purchase goods and services; production, where individuals are unable to find employment; involvement in local and national politics and organizations; and finally, social interaction and family support. Social inclusion is widely agreed to be:

- relative to a given society (place and time);
- multi-dimensional (whether those dimensions are conceived in terms of rights or key activities);
- dynamic (because inclusion is a process rather than a state); and
- multi-layered (in the sense that its causes operate at individual, familial, communal, societal and even global levels).

On the relationship between social inclusion and social exclusion, the point has been made that a person can be included in smaller, closer family or peer groups, yet at the same time excluded from the mainstream, or vice versa.

A further important distinction is between risk factors for social exclusion and indicators of social exclusion (or inclusion) itself. For example, being from a Pakistani or Bangladeshi background, lone parenthood, and chronic ill health are all risk factors for social exclusion but are not sensibly thought of as dimensions of social exclusion itself: they are indicators neither of rights nor of participation.
Social quality

For some people the concepts of social exclusion and inclusion are still too narrow as a basis for the development of effective local and national social policies (Berman and Phillips 2000). Beck et al (1997) have proposed an alternative overarching conceptual framework of 'social quality', defined as: "The extent to which citizens are able to participate in the social and economic life of their communities, under conditions which enhance their well-being and individual potential" (Beck et al 1997;p3).

This concept of social quality is similar to our conception of quality of life assessment in mental health (Oliver et al, 1996) in that it encompasses both objective and subjective interpretations. Social quality has at least four overlapping elements that bear a close resemblance to the life domains of our quality of life assessments. They are: social-economic security (protection against unemployment, poverty, ill-health and other material deprivations); social inclusion/exclusion (equal access to supportive infrastructures, labour conditions and collective goods); social cohesion/anomie (the availability of social networks, equal access to services); empowerment/disenfranchisement (enabling people to develop their full potential in social economic, political and cultural processes). Vogel's (1994) taxonomy of social quality is virtually the same as the life domains covered by our quality of life measures, i.e.: health, education, work, income, housing, safety, social attachment, leisure (Vogel 1994 p260).

Finally, there is considerable debate about the perception of the term ‘social inclusion’ itself and whether a subjective perception of exclusion is necessary or sufficient to identify an underlying state of social exclusion (Le Grand and Richardson, 2002). Information about an individual’s subjective state is clearly important in any evaluation but especially where low self-esteem, experience of discrimination, and long-term deprivation are prevalent, individuals’ expectations may be so reduced that subjective assessments of well-being must be treated with caution (Nussbaum, 2001; Burchardt, 2005), although Evans & Huxley (2005) have shown that most of the time, deterioration in material well-being is accompanied by a decline in subjective well being and vice versa in general population, and mentally disordered groups. Where counterintuitive findings apply, for instance in those with severe mental illness, subjects are more likely to make aspirational ratings rather than resigned ones (ie where resignation is denoted by high subjective QoL rating, when adverse circumstances are experienced). Lelkes (2005) found essentially the same results based on large survey data samples.

Related concepts and their measurement

It may be worthwhile taking some time to examine the question of which other concepts or constructs abut or overlap with social inclusion, and from which concepts it helpfully can be distinguished. Clear candidates on the basis of our concept mapping groups are citizenship, social capital, social participation, social cohesion, social exclusion, social support, community perceptions and quality of life. A number of papers usefully
address some of these interrelationships and there have been some attempts to incorporate them into a single model (see Appendix 1 for instance and Berger-Schmitt and Noll, 2000).

Citizenship
Stewart (1995) distinguishes state citizenship from democratic citizenship. Community citizenship refers to the possession by members of a community of a range of social and cultural rights and responsibilities by virtue of their membership of that community and as a distinct element of their national citizenship rights. Roche (1997) suggests that citizenship can be seen as the core of what it is that social exclusion processes exclude people from, and the core of what social inclusion policies promise to include people in.

Social cohesion
Domains of social cohesion according to Forrest and Kearns (2001) are: common values and a civic culture; social order and control; social solidarity and reduction in wealth disparities; social networks and social capital; place attachment and identity.

Some definitions of social cohesion are close to that of social capital (see next section) viz Stanley (2004) who defines social cohesion as the willingness of members of a society to cooperate with each other in order to survive & prosper. Willingness to cooperate means they choose freely to form partnerships & have a reasonable chance of realizing goals, because others are willing to cooperate & share the fruits of their endeavors equitably. Friedkin (2004) argues that social cohesion is the causal system that determines individuals’ membership attitudes and behaviors. Thus social cohesion is a property of communities and groups, whereas 'being socially included' is an attribute which an individual may or may not have.

Social capital
Components of social capital according to the HDA (1999) are participation in the local community; reciprocity; feelings of trust and safety; social connections; power; community perception. Nevertheless, community perception is regarded by others as a psychological concept in its own right (Pooley et al 2005; McMillans and Chavis 1986; Perkins et al 1990); participation is a key component of social inclusion according to many authors (Levitas, Burchardt etc). According to Forrest and Kearns (2001) social capital components are: empowerment; participation; associational activity; supporting networks and reciprocity; collective norms and values; trust; safety; belonging. Only participation and associational activity are widely regarded as social inclusion components.

The most widely cited definitions of social capital come from the Harvard political scientists Robert Putnam et al. (1993, p. 35) who define social capital as “a set of horizontal associations among those who have an affect on a community, and these can take the form of networks of civic engagement” and “features of social organizations such as networks,
norms and truths that facilitate coordination and cooperation for mutual benefit”.

Bourdieu understands social capital to be a process of deliberately constructing sociability in order to acquire the benefits of being part of a group. That is, social networks are not a natural given and must be constructed through investment strategies, which are grounded in the institutionalization of group relations. The latter are useable as a source of other benefits. Bourdieu (1986) suggests social capital is comprised of two elements: 1. The social relationship that enables individuals to gain access to resources possessed by their associates. 2. The amount and quality of those resources.

Social capital is a multi-dimensional concept that encompasses a number of theoretical distinctions. Grootaert and van Bastelaer (2002, p. 10–11) suggest there are two types of social capital: structural and cognitive. Structural social capital facilitates information sharing, and collective action and decision making through established roles, social networks and other social structures supplemented by rules, procedures, and precedents. As such, it is a relatively objective and externally observable construct and relates to the participation element of social inclusion. In contrast, cognitive social capital refers to shared norms, values, trust, attitudes, and beliefs. It is therefore a more subjective and intangible concept.

A further distinction is often made between ‘bonding’, ‘bridging’ and ‘vertical’ forms of social capital. Bonding social capital relies on strong ties between people. It is inward-focused and characterised by homogeneity, loyalty and exclusivity. Bonding social capital has a significant downside as a tightly-knit homogeneous community might be one intolerant of individual diversity, asphyxiating to live in and exclusionary to outsiders (Baum, 1999).

Bridging social capital, in contrast, links diverse groups and people. It is characterised by weak ties, has an outward focus and is likely to foster social inclusion. It is commonly recognised that this form of social capital is useful for finding employment (Stone et al., 2003). As employment is key to many conceptions of social inclusion (Stewart, 2000), it can often mean the difference between ‘inclusion’ and ‘exclusion’ for some people.

‘Vertical’ social capital is often distinguished from ‘horizontal’ social capital by virtue of the connections being made within a hierarchical structure to government and other institutions, rather than within and between communities. Vertical social capital provides a community’s institutional integration and, together with bridging forms of social capital, equates to an inclusive and cohesive society (Colletta and Cullen, 2000, Berkman and Kawachi, 2000). Moreover, socially cohesive societies high in social capital are more likely to achieve the twin virtues of sustainable economies and human development, according to Stanley (1997). Thus high social capital is likely to be associated with greater chances of social inclusion, but is not sufficient to achieve social inclusion. Social inclusion refers to a
broader range of domains, including for example realisation of rights, labour market integration, and so on.

Social support
It has been said that the measures of social support are as varied as the number of investigators. Veiel and Baumann (1992) created a useful conceptual framework in which they distinguished everyday support from crisis support, instrumental support from psychological support, and subjective from objective appraisals of support. Numerous support measures have been reported (see Veiel and Baumann; and Sarason et al 1983) in mainly in the fields of psychology and social psychology. So, as for social capital, social support is an important facilitator of social inclusion, but is not sufficient to achieve it.

Social participation
There are a number of ways to define and measure social participation. There was considerable interest in measuring participation in 1950s USA (eg Beal 1956, Black 1957; Rose 1959; Harp 1959). Earlier Chapin (1924, 1928, 1939) developed a brief scale of participation, that really amounted to a measure of organisational membership. Parker’s (1983) elaboration of Chapin’s work was also confined to activities (committee or informal) within formal voluntary organisations, rather than any other type of participation, and this approach is probably rather limiting in the current context.

Of all the other concepts social participation is perhaps the closest to social inclusion, since most concepts of inclusion incorporate it as a key component.

Social networks
Social networks have been defined as the web of social relationships that surround an individual and the characteristics of those ties (Mitchell, 1969; Laumann, 1973; Fischer et al. 1977; Fischer, 1982). Burt has defined network models as describing “the structure of one or more networks of relations within a system of actors” (Burt, 1982, p. 20). Network characteristics cover: range or size (number of network members); density (the extent to which the members are connected to each other); boundedness (the degree to which they are defined on the basis of traditional group structures such as kin, work, neighborhood); homogeneity (the extent to which individuals are similar to each other in a network); related to network structure, characteristics of individual ties include: frequency of contact, (number of face-to-face contacts and/or contacts by phone or mail); multiplexity (the number of types of transactions. According to Berkman et al (2000) social networks operate at the behavioral level through four primary pathways: (1) provision of social support; (2) social influence; (3) on social engagement and attachment; and (4) access to resources and material goods.

Social networks, like social support and social capital, help to promote social inclusion, but in the absence of other mechanisms, are unlikely to be sufficient to attain social inclusion.
Quality of life

The Bristol Social Exclusion MatriX measure incorporates a section on quality of life that includes such things as self-esteem and personal efficacy, personal development etc. We would regard these rather as psychological or cognitive outcome indicators, improvement in which measures might be the target for service providers and service users. Generally these are not accepted components of QoL measures, which are often health-related and used as disease-specific treatment outcome indicators, and which, when generic, usually cover material or objective circumstances and subjective well being in very similar life domains to those identified in the social inclusion and exclusion literature. Berger-Schmitt and Noll (2000) incorporate QoL into their overarching model as the ultimate objective for social policies, including inclusion policies. We find their model coherent and appealing. So social inclusion can be seen as a major contributory factor to an improved quality of life in both individual life domains and quality of life overall, with the caveat that for some people in some circumstances their conscious choice to exclude themselves could enhance their subjective quality of life in a particular domain.

Well being

In recent years there has been a shift from a predominant concern with mental illness to an interest in the mental health and well-being of the whole population - public mental health. This has been accompanied by a growing interest in developing indicators to measure different dimensions of positive mental health, to accompany indicators of psychiatric morbidity (Stewart Brown, 2002). Affectometer 2 has been identified as a promising scale (Kammann & Flett, 1983; Stewart-Brown, 2002) and has been included in the Health Education Population Survey (HEPS) in Scotland. Affectometer 2 has been psychometrically validated in the UK and a revised, shortened scale, the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), developed to better assess population positive mental health (Tennant et al 2006). In the US, Keyes (1998) confirmed that social integration, social coherence, social contribution, actualization and social acceptance are the components of social well-being. Well being is found in this study to be an achievement facilitated by age and educational attainment. So as in relation to quality of life, social inclusion should contribute to well being with the same caveat, that under certain circumstances the choice to refuse inclusion may improve well-being. In principle, of course, someone could be "well" in the sense of having positive mental health, but nevertheless be socially excluded. Inclusion implies something positive about the relationship between the individual and society, while well-being is about the individual in him/herself.
3 METHODS

In this section, the various methods used in this study are described. We begin with a description of the concept mapping methods, which is followed by a description of the strategies for the review of evidence and measures based on literature and web-based searches. Finally, we describe the processes for synthesising these data (collected from concept mapping and reviews).

3.1 CONCEPT MAPPING METHOD

Concept maps are graphical tools for organizing and representing knowledge, which is sometimes used for measurement development as in this case with the creation of a social inclusion index (Trochim, 1985; Trochim 1989a; 1989b;1989c).

The process
There are six steps in the process:

**STEP ONE: Preparation**

- Identifying and obtaining a sample: Identify who are the participants.
- What is the focus?

Sampling Procedures

We arranged 9 groups to represent a reasonably wide range of persons. The groups lasted about one hour to one and a half hours. In total there were 66 participants in 9 groups, which were conducted over a three month period. Groups tended to be London based, but two groups held outside of London, broadened the perspective. Groups four, five and six were contacted through the voluntary sector team of a London local authority. All groups funded or partially funded by the local authority were contacted. The participating groups volunteered to take part in the study. Group seven also volunteered after contact was made by the group facilitator. This group was from a neighbouring London borough. Attempts to generate a general population group by placing posters in libraries, supermarkets, community groups and newsagents throughout the borough were unsuccessful. Therefore a snowball sample was generated by asking local contacts to nominate someone that they knew, who was not a mental health or social care professional, nor a mental health service user. The group of users and carer was contacted via a coalition member of the NIMHE SI Coalition.

Each group was facilitated or recorded by the same core group. MM was constant throughout. In all cases the resulting maps were photographed and/or copied, and the original flip charts retained for checking and any future further analysis beyond that for the present purpose.
Participants of the groups were:

1. Staff members of a mental health research group including admin staff, a professor, research assistants, research fellows, senior researchers and a trainee psychologist were invited to attend. There were seven participants.
2. Members of the NIMHE social inclusion network group were invited to participate. This was the largest group with 12 participants from various organisations and different professions.
3. The third group was held with ten first year social work students at the beginning of the current academic year.
4. The fourth group was held with a local authority led multi-disciplinary working group which focuses primarily on mental health, employment and social inclusion. Consequently there were representatives from the health sector, voluntary sector and the local authority. There were ten participants in this group.
5. The fifth group was held with the staff and volunteers of a women’s forum. A voluntary organisation, which offers advice, counselling and housing support for women in crisis. This group had seven participants.
6. The sixth group was a mix of staff from two organisations, an age concern group and a black and minority ethnic cultural community group. There were a total of five participants.
7. The seventh group involved participants who attended an age concern drop in centre. This group comprised three older people and two trainee social workers.
8. The general population group was obtained via a snowball sample. There were six participants.
9. The mental health user and carer group comprised of three users and one carer from a social inclusion forum led by the social services of a city council.

**STEP TWO: Generating statements**

- Participants in each group generated statements starting by writing three things that come to mind when they hear the term “social inclusion”. These were written on yellow Post-its and stuck to a large board or wall and clustered by placing similar statements close together and dissimilar statements further apart. Each group was then asked to add further statements to existing clusters or to start new ones.

- Encouraged to generate statements

- No criticism as to right and wrong answers

- Participants were asked for clarity of jargonistic terms so that not only facilitator but others in the group might understand.

**STEP THREE: Structuring of statements**
When there are no more statements to add, or a maximum of 150 has been reached, participants were asked to further cluster and redistribute the statements after further discussion and agreement had been reached. Participants were then asked to label clusters and describe the links between the clusters as well as how each cluster relates to each other. Due to time constraints statements were not rated as in the conventional methodology of concept mapping but a content analysis approach was adopted using concepts drawn free hand according to the description given by participants. Further analysis was then conducted as described in steps five and six.

**STEP FOUR: Representation of statements**

- Participants were asked to consider how clusters were associated if at all (once they were labelled). Some clusters in a few groups went without labels because of time constraints or because agreement could not been reached. Participants explained to the facilitator how they saw the clusters fitting together or images of how statements and clusters should be represented. Consequently concept maps were drawn “free-hand” by the researcher/facilitator according to the ideas given by each of the groups.

- This group exercise is being repeated with several groups and then each concept map compared and rationalised (pattern matching) if possible, by the researchers and the expert group into a single map. If this is not possible, then the result will be several different maps which are incommensurate.

- While there may have sometimes been disagreement with regards to the placement of statements and clusters, the final map for each group depicts an understanding among participants about the concept of social inclusion.

- Concepts within clusters are associative and not causal. Links between clusters also show association but not causation.

**STEP FIVE: Interpretation of maps**

In order to use the map to address the key components of social inclusion, a number of tables were generated using a contents analysis approach. Nine maps were generated consisting of 444 statements and 66 clusters. Similar items from each map were grouped together to create key elements of social inclusion. The most common themes from the 9 maps are given in the results.

**STEP SIX: Utilisation of the concept maps**

Further discussion by the expert group will agree upon a core set of themes/areas for inclusion in the index and explore potential indicators for each area.
3.2 LITERATURE SEARCH METHOD

Curran et al (in press) have described the challenges associated with literature searching social science concepts, with particular reference to social exclusion and mental health. The challenges encountered include inconsistent definitions of social phenomena, differing use of key concepts across research fields and practical problems relating to database compatibility and computer processing power. As a result searches of this type tend to generate a large volume of publications, not all of which are directly relevant. Strategies for dealing with the high volume need to be developed, in order that a focused search is produced, which identifies the most relevant publications, without introducing bias or risking omitting important references. For the purposes of this search, we have borrowed from some aspects of the works of Curran et al (in press, notably not sampling) and Evans (2004) to develop a focused search strategy. This involves defining the research questions, identifying the key variables, specifying search engines, search terms and search fields, stipulating inclusion and exclusion criteria, describing search procedures (eg limits, combinations etc), and finally screening and selection.

Aims: this search strategy will address five specific research questions pertinent to a study of social inclusion in the general population and among people with mental ill health, namely:

- How is the concept of social inclusion operationalised?
- What models and measures of social inclusion exist currently, or are being developed?
- What measures of social exclusion or components of social inclusion (as identified in concept mapping exercises) are available?
- Are existing measures reliable and valid?
- What methodological and/or measurement issues need to be considered in relation to social inclusion of included and excluded groups?

The key variables therefore are social inclusion and exclusion, mental health and populations.

Data Sources

A strategically focused approach to searching was required to cope with the volume of literature. Searches that take account of the composition and content of a concept can help to isolate the most relevant material. Those that take account of the coverage, availability (life-span) and different disciplinary perspectives of bibliographic databases ensure that pertinent information is not missed (Topfer et al, 1999) and that precision is increased (Matthews et al, 1999). The inclusion of a wide range of electronic databases is likely to produce a comprehensive and efficient search (Matthews et al, 1999; Topfer et al, 1999; Minozzi et al, 2000).

Therefore the search strategy drew upon eight standard databases (Medline, Old Medline (pre 1966), EMBASE, Psychinfo, IBSS, HMIC and...
Web Of Knowledge (SSCI & SCI)) and seven additional electronic data sources. The standard search engines provided coverage of clinical medicine and bio-medical research, nursing and healthcare, psychological, social, behavioural, and health sciences, economics and political science and anthropology, and included some grey literature sources via HMIC, which incorporates the DH and Kings Fund’s library and information resources. Nevertheless, coverage of the socially orientated databases was extended to include ASSIA (post 1987), Sociological Abstracts (post 1963) and Social Services Abstracts (post 1980), ERI, Econlit, and Academic Search Premier and Business Source Premier using ECOHOST, in order to address problems of limited coverage (IBSS) and short-life span (SSCI) (see Evans, 2004). By extending the search in this way coverage of the literature on inequality, social structure, ethnic populations, social change, social problems and social welfare, unemployment, criminology, education, family, and other sociological constructs was encompassed. Searches of ERI ensured coverage of literature relating to measurement, tests and evaluation.

Searches of these databases maximised retrieval of journal articles covering a range of perspectives, which should minimise the potential for publication bias.

The adopted strategy involved multiple searches of the 15 databases, using 5 search engines: OVID – covering Medline & Old Medline, EMBASE, Psychinfo, IBSS, HMIC; CSA – covering ASSIA, Sociological Abstracts, Social Services Abstracts and ERI; Web of Knowledge – covering SSCI & SCI; ECOHOST – covering Academic Search Premier and Business Source Premier; and Econlit. Curran et al have highlighted the challenges of literature searches of social concepts, in particular the different use of key concepts across disciplines, issues of definition and the different capabilities of search engines to process, and limit searches. Consequently, slight differences in approach were required between OVID (which has the capacity to define terms and limit searches most effectively), and CSA, Web of Knowledge and the other search engines used, which require more basic strategies and are less capable of imposing limits on searches. Nevertheless, the fundamental properties of all searches were the same.

**Search Terms**

Search terms relating to social inclusion, exclusion and contributing factors mirrored the positive terms used in Curran et al’s (in press) review of social exclusion and mental health. The term social exclusion was retained, for completeness. The exact details of the searches are outlined below.
<table>
<thead>
<tr>
<th>Source</th>
<th>Search terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVID (Medline, Old Medline, EMBASE, Psychinfo, IBSS &amp; HMIC)</td>
<td>Social$ inclu$ OR social exclusion OR social capital OR social$ cohesi$ OR social$ engage$ OR social$ involve$ OR social participation OR social interaction$ OR social$ integrat$ OR social responsibility$ OR social wellbeing OR social well-being (in abstract or keyword)</td>
</tr>
</tbody>
</table>
| CSA (Sociological Abstracts, Social Services Abstracts, ERIC, ASSIA)*   | Social inclusion OR socially included OR socially Inclusive  
Social exclusion OR socially excluded OR socially exclusive  
Social Capital  
Social cohesion OR socially cohesive  
Social) engagement OR Socially engaged  
Social involement OR socially involved  
Social participation  
Social interaction OR social interactions  
Social integration OR socially integrated  
Social responsibility OR social responsibilities  
Social wellbeing OR social well-being (in abstract or keyword) |
| Web of Knowledge (SSCI & SCI)                                        | Social$ inclu$ OR social exclusion OR social capital OR social$ cohesi$ OR social$ engage$ OR social$ involve$ OR social participation OR social interaction$ OR social$ integrat$ OR social responsibility$ OR social wellbeing OR social well-being (in abstract or keyword) |
| Econlit                                                               | socia* inclu*" OR "social capital" OR "social* cohesi*" OR "social* engage*" OR "social* involve*" OR "social participation" OR "social interaction*" OR "social* integrat*" OR "social responsibility*" OR "social wellbeing" OR "social well-being" OR "social well being" in Abstract or Author Supplied Abstract |
| ECOHOST (Academic Search Premier & Business Source Premier)           | socia* inclu*" OR "social capital" OR "social* cohesi*" OR "social* engage*" OR "social* involve*" OR "social participation" OR "social interaction*" OR "social* integrat*" OR "social responsibility*" OR "social wellbeing" OR "social well-being" OR "social well being" in Abstract or Author Supplied Abstract |

Due to the high volume of hits generated by the multiple, truncated terms search in CSA (>13,500) several more manageable searches were undertaken using the specific terms included in the table. Similarly, in Web of Knowledge the multiple, truncated terms search was followed by a ‘within-search’ search for the specific terms used in CSA.

Due to our focus on models and measurement, these social inclusion searches were combined with a measurement-related search that used the terms outlined below. Previous work by the authors has shown that title searches can be more effective than abstract and keyword searches.
in identifying relevant literature, particularly those relating to social science constructs (Evans, 2004). Therefore title searches of the following measurement terms were undertaken:

measure OR measures OR measurement OR index OR indices OR indicator OR indicators OR scale OR scales OR tool OR tools OR assessment OR assessments OR instrument OR instruments OR questionnaire OR questionnaires OR form OR forms OR profile OR profiles OR test OR tests OR instrument OR instruments OR questionnaire OR questionnaires OR form OR forms OR profile OR profiles OR test OR tests OR schedule OR schedules.

Search Limits

In order to produce a focused research that was as free as possible from bias, certain limits were placed when searches were being conducted, with the effects of enforcing these limits being monitored at each stage. In accordance with the Curran et al review of social exclusion and mental health, wherever possible searches were limited to English language, peer-reviewed journals that included abstracts, reported on human subject in the period 1948-2007. Unlike Curran et al, we did not limit the focus to adults of working age as we needed to examine similarities and differences in the social inclusion construct, across the age range, and because we did not want to exclude unwittingly, measures of social inclusion among younger or older age-groups. In OVID only ,we were able to limit the search to papers reporting on tests & measures. While duplicates were removed effectively using OVID, duplicate removal was less effective using CSA & WoK. It was not possible to quantify the number of duplicates across all databases. In order to assess the impact of limiting our search to English language, peer-reviewed journals where possible, a small number of searches that did not impose such limits were also undertaken, and these were compared with the limited searches.

Process

Searches were conducted by SE & DMcD, who also screened article titles and abstracts for relevance, and classified retained articles as follows:

1) Measures of inclusion or components
2) Conceptual papers relevant to social inclusion or measurement
3) Measures of other concepts or none of the above

Categorisations were then checked by a second reader, who made a few minor classification changes, which were then checked with the first reader. Category 1 papers and the most pertinent category 2 papers were retrieved and read, in order to determine whether they could be included in the review of concepts and measures, or discussion. Finally, the references of the most relevant papers were checked, in order to identify any other publications that might be of interest.
3.3 REVIEW OF MEASURES METHOD

Measures found within the formal literature review, web-searches, and from the NIMHE social inclusion coalition sources, were all assessed for their relevance to the concept of social inclusion. Any psychometric properties will also be reported. A summary table showing which papers from the literature review are retained (because they contain measures of social inclusion or constituent elements) and which are excluded, and why, will be presented as Appendix 2.

Published and unpublished measures will then be reviewed in terms of the possibility that they represent measures of social inclusion or a related concept and conclusions drawn on each of them.

3.4 SYNTHESIS BY EXPERT GROUPS

Draft versions of each of the results sections will be reviewed by expert group members, and suggestions regarding synthesis of the findings gathered. The final draft version will also be reviewed by NIMHE Coalition members.
4 RESULTS

4.1 Results: the concept mapping groups

In all, nine maps were produced:

MAP 1: Mental health research group
MAP 2: Members of the Social Inclusion network group (professionals and CSIP)
MAP 3: First year social work students
MAP 4: Members of the Mental Health and Employment Working Group. A multi-disciplinary group of professionals
MAP 5: Women’s Forum
MAP 6: Staff of a Black and Minority Ethnic Cultural Association and an Age Concern
MAP 7: Members of a Drop-In Centre for older people (over 55s)
MAP 8: General Population
MAP 9: Mental Health Service users and carers

Overview

The table below shows the number of participants, clusters and statements generated in each group.

<table>
<thead>
<tr>
<th>Group</th>
<th>Description</th>
<th>Participants</th>
<th>Cluster</th>
<th>Statements</th>
<th>Main pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Research Group</td>
<td>Researchers and administrator</td>
<td>7</td>
<td>8</td>
<td>35</td>
<td>Concentric pattern with the individual at the centre.</td>
</tr>
<tr>
<td>Members of the Social Inclusion network group</td>
<td>Various organisations and mental health professions</td>
<td>12</td>
<td>5</td>
<td>51</td>
<td>Tree diagram with branches depicting clusters as steps to inclusion</td>
</tr>
<tr>
<td>Social work students</td>
<td>First year. Varying levels of experience</td>
<td>10</td>
<td>6</td>
<td>39</td>
<td>Clusters polarised into social inclusion and exclusion</td>
</tr>
<tr>
<td>Mental health, employment and social inclusion working group</td>
<td>local authority led multi-disciplinary working group</td>
<td>10</td>
<td>10</td>
<td>50</td>
<td>Individuality is the aim; support is the foundation/base. All clusters interconnected in a sometimes hostile social environment.</td>
</tr>
<tr>
<td>Women’s Forum</td>
<td>A voluntary organisation:</td>
<td>7</td>
<td>9</td>
<td>49</td>
<td>See saw with social inclusion</td>
</tr>
<tr>
<td>Group</td>
<td>Description</td>
<td>Participants</td>
<td>Cluster</td>
<td>Statements</td>
<td>Main pattern</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>---------</td>
<td>------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Staff of a Black and Minority Ethnic Cultural Association and an Age Concern group</td>
<td>Information and advice primarily for asylum seekers and refugees from a particular community</td>
<td>5</td>
<td>5</td>
<td>48</td>
<td>The Evolution of Communities: The Continuous Struggle for Social Inclusion. Different communities may currently be at any stage of the evolutionary process for social inclusion</td>
</tr>
<tr>
<td>Age Concern Drop in Centre</td>
<td>Keep fit classes; Lunch club</td>
<td>5</td>
<td>5</td>
<td>48</td>
<td>All clusters are interconnected</td>
</tr>
<tr>
<td>General population</td>
<td>1 male; 5 females Diverse backgrounds Snowballed sample</td>
<td>6</td>
<td>10</td>
<td>65</td>
<td>All clusters are interconnected with social inclusion at the centre. Social inclusion is influenced by the clusters which represent the factors of life that influence chances of being included or excluded</td>
</tr>
<tr>
<td>City Council Social services social inclusion forum</td>
<td>3 service users; 1 carer</td>
<td>4</td>
<td>8</td>
<td>59</td>
<td>All clusters are interconnected with the essence of social inclusion at the centre.</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td>66</td>
<td>66</td>
<td>444</td>
<td></td>
</tr>
</tbody>
</table>
The groups in more detail (Maps are reproduced as Appendix 4)

**MAP 1: Mental Health research group**
Group members recognised that one consequence of discrimination and structural inequities was to limit life chances for some individuals and groups, so that their chances of inclusion were restricted compared to others. This map distinguishes inclusion levels, or layers, while suggesting that the values, choice and rhetoric apply across the board. It distinguishes social networks from material conditions.

**MAP 2: Members of the Social Inclusion network group (mental health professionals and CSIP)**
This map came from the mental health professionals. One important observation made by this group was to divide the map into two parts, one representing the individual aspects of inclusion and the other the societal aspects. This conforms to some degree to the notion in the original call for proposals for the present piece of work that social inclusion has subjective and objective aspects. This distinction carries forward into several of the measures that the research group identified. These are examined further in the next section.

**MAP 3 Social work first year students**
The social work students focussed on social policy and inequity. Social work students have been shown to have more inclusive attitudes than other social and natural science students (Schwartz & Armony-Sivan 2001). These students also focussed on excluded groups, but labelled these ‘Models of exclusion’. They saw that some of the rights of the individual, to respect, arose from more global human rights movement. Note that the concept of rights did not figure in the map created by the older people’s group or many of the other maps. The student’s map reflects the UN concept of a socially inclusive society, which is ‘based on respect for all human rights and fundamental freedoms, cultural and religious diversity, social justice and the special needs of vulnerable and disadvantaged groups, democratic participation and the rule of law.’

**MAP 4: Members of the Mental Health and Employment Working Group. A multi-disciplinary group of professionals**
The right to have access to support was a central theme in some groups, especially those with consumers and professional workers in them. Some groups made support the central theme, and attached other conceptual areas to it as the main item.

**MAP 5 Women’s Forum**
It was widely thought that exclusion is not the obverse of inclusion, in particular that efforts to promote inclusion differ from those to prevent or reverse exclusion (on the whole). Nevertheless, the women’s forum saw this as a kind of balancing act (or see-saw) in which various factors acted to push in one or other direction. The women’s group focussed on community, discrimination and ignorance, conflict within the home and
wider society as well as employment, education, finance, neighbourhoods and housing. This map is essentially dynamic, like map 1, but is not circular.

**MAP 6: Staff of a Black and Minority Ethnic Cultural Association and an Age Concern group**
The dynamic nature of inclusion means that the main focus may be changing all the time, and over time, and what seems to be most important, depends on where you are in the process. So the older people (MAP 7) tended to focus on media-promoted excluded groups and the change (deterioration) in family values over time, whereas the BME group (MAP 6) saw themselves as part of an on-going and developing struggle for inclusion. This map shows an essentially circular pattern. This may be an indication that subjective responses are dependent upon the extent of one’s exclusion in different respects or domains.

**MAP 7: Members of a Drop-In Centre for older people (over 55s)**
Older participants did tend to see things in terms of age differences, changes in family life, and some resistance to social change – see the integration box in MAP 7. They also gave a specific role for actions to promote social inclusion, which some people have called ‘social inclusion activity’. For example, Staffordshire County Council has defined a social inclusion activity as a policy, strategy or service which: targets specific individuals, groups or neighbourhoods likely to be affected by multiple forms of economic, social or environmental deprivation; deals with the causes of deprivation rather than (or as well as) its symptoms; takes a holistic approach to tackling deprivation; and works in partnership with local people or communities of interest.

**MAP 8 The general population**
Finally, the general population map (MAP 8) also has excluded groups, and mirrors some of the older people’s Maps in tone and content. There is a rather resigned tone to the contents, and less positive and hopeful statements than in groups of service users (Map 9) and professionals (Map 2 and 4). The general population group explicitly identified the media and politicians as having a role in the perpetuation of exclusion. The attitudes displayed here are more exclusionary than inclusionary, which is perhaps to be expected of society in its general form?

**Map 9 Mental health service users group**
The service users confined much of the material aspects of inclusion into one area, and did not have the same range in this area as other groups. The main preoccupation of this excluded group, was with the processes of disadvantage and discrimination that lead to them feeling excluded, and the problems associated with services not always being able or set up to, enable their inclusion. This group regards choice in service terms as illusory and they feel passive in the face of discriminatory attitudes in society and in services.
Summary

The most frequently occurring individual items from all the groups were counted and are listed in Box 1.

**BOX 1: Most frequently occurring items in the concept mapping groups**

**Ranking of items by order of frequency within maps**

**Most common theme**
1. Social network and support e.g. friends and family

**Second most common themes**
1. Opportunities
2. Neighbourhood and built environment e.g. ghettos, deprivation, surroundings
3. Financial stability
4. Employment
5. Disadvantaged and excluded groups
6. Acceptance including being part of society

**Third most common themes**
1. Discrimination including stigma
2. Representation: being visible and listened to; having a say
3. Participation
4. Language
5. Housing and life chances
6. Health and well being
7. Engaging in community
8. Diversity, difference, integration
9. Decreased exclusion/opposite of exclusion/including people who have been excluded
10. Choice/Freedom/Control/Power/Responsibility
11. Access
12. Service provision

**Fourth most common themes**
1. Confidence/Sense of Purpose/Fulfilment/Achievement
2. Isolation
3. Having a meaningful, recognised and valued role
4. Barriers to inclusion
5. Understanding
6. People’s behaviour
7. Transport and mobility
8. Safety, fear, crime, conflict
9. Respect
10. Religion (ignorance and tolerance)
11. Education
Most commonly, people referred to social networks and support from family and others. However, most groups then identified social structural factors that form a framework for conceptualising social inclusion; these include some of the categories identified in the Burchardt review—income, employment, housing, social networks, and participation; others included health, safety, leisure, access to services, transport, religion and education.

One or two groups made the point that there is often pressure to conform in order to become valued, and there was suspicion about the motives behind the UK government’s social inclusion agenda at the societal level. This appears as ‘rhetoric’ and ‘professional cynicism’ in more than one group (see Maps 1 and 4 for instance). Several times the point was made that some individuals and some groups choose to exclude themselves (ironically ‘keeping oneself to oneself’ is widely prized in some parts of UK society). This appears in the groups with older people (MAP 7) and the general population (MAP 8).
4.2 RESULTS: THE LITERATURE SEARCH

### TABLE 3: LITERATURE RESULTS

<table>
<thead>
<tr>
<th>Terms/engine</th>
<th>OVID</th>
<th>WOK</th>
<th>CSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social$ inclu$ Social$ exclu$ OR social capital OR social$ cohesi$ OR social$ engage$ OR social$ involve$ OR social participation OR social interaction$ OR social$ integrat$ OR social responsibilit$ OR social wellbeing OR social well-being.mp</td>
<td>ALL DONE 75,585</td>
<td>Article, English, 1945-2006 95,778</td>
<td>1948-2006 Social(ly) inclusion/ed/ive 1,042 Social(ly) exclusion/ed 1,048 Social(ly) cohesion/ive 2,482 Social(ly) engage/d/ment 188 Social(ly) involve/d/ment 204 Social participation 1,232 Social interaction/s 6,360 Social integration/ed 4,573 Social responsibility/ies 2,340 Social wellbeing/well-being 451</td>
</tr>
<tr>
<td>2 Limit 1 to abstracts</td>
<td>54,582</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Limit 2 to english language</td>
<td>50,644</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Limit 3 to human/humans</td>
<td>43,769</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Limit 4 to peer-review jnls</td>
<td>37,552</td>
<td></td>
<td>Social(ly) inclusion/ed/ive 791 Social(ly) exclusion/ed 612 Social capital 2,049 Social(ly) cohesion/ive 1,518 Social(ly) engage/d/ment 153 Social(ly) involve/d/ment 141 Social participation 943 Social interaction/s 4,692 Social integration/ed 3,051 Social responsibility/ies 1,384 Social wellbeing/well-being 363</td>
</tr>
<tr>
<td>6 Limit 5 to 1948-2007</td>
<td>37,476</td>
<td>95,778</td>
<td></td>
</tr>
<tr>
<td>7 Limit 6 to tests &amp; measures</td>
<td>24,368</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Limit 7 to age 18-64</td>
<td>18,858</td>
<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>measure$ OR index OR indices OR indicator$ OR scale$ OR tool$ OR assessment$ OR instrument$ OR questionnaire$ OR form$ OR profile$ OR test$ OR schedule$).m_titl.</td>
<td>1,734,823</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Combine 6 &amp; 9</td>
<td>2,603</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Remove duplicates</td>
<td>2,032</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Combine 7 &amp; 9</td>
<td>2,048</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Remove duplicates</td>
<td>1,607</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Combine 8 &amp; 9</td>
<td>1,620</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Remove duplicates</td>
<td>1,314</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>measure OR measures OR measurement OR index OR indices OR indicator OR indicators OR scale OR scales OR tool OR tools OR assessment OR assessments OR instrument OR instruments OR questionnaire OR questionnaires OR form OR forms OR profile OR profiles OR test OR tests OR schedule OR schedules.m_titl.</td>
<td>1,179,160</td>
<td>Article, English, 1945-2006 &gt;100,000</td>
</tr>
<tr>
<td>Step</td>
<td>Action</td>
<td>Count</td>
<td>Notes</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>18</td>
<td>Remove duplicates</td>
<td>1,716</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Combine 7 &amp; 16</td>
<td>1,811</td>
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<td>20</td>
<td>Remove duplicates</td>
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<td>Combine 8 &amp; 16</td>
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<td>22</td>
<td>Remove duplicates</td>
<td>1,138</td>
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<td>23</td>
<td>From 20 keep</td>
<td>243</td>
<td>Search for specific terms within search 179 (inc duplicates)</td>
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<tr>
<td>24</td>
<td>Retained: soc inclusion measurement, measurement of some element of social inclusion or potential conceptual relevance</td>
<td>99 (No duplicates within; Duplicates with CSA &amp; WOK)</td>
<td>87 (Duplicates within and across databases)</td>
</tr>
</tbody>
</table>

144 articles were retrieved and read and 76 of which were discarded as definitely not containing any measures, data, or psychometric reports or conceptually irrelevant, and 68 which apparently contained conceptually relevant material, or measures of inclusion or component parts.
Searches of Econlit and ECOHOST generated a further 706 references found, of which 13 duplicates were eliminated and 57 articles selected. These all duplicated papers retrieved via other sources.

4.3 RESULTS: WEB SEARCHES

We conducted two web searches on each of these search engines: Look Smart; National Quality measures clearinghouse; Dogpile; Google Advanced; Question Bank; Copernic, one using the terms ‘measure of social inclusion’ and the other ‘social inclusion index’. There were 1955 hits. Many of the indexes referred to on websites are social indicator related, and far fewer relate to perceived inclusion measures, and of course none of the indicators identified are subject to any form of quality control. When we put these results together with the formal review of measures and the information from the NIMHE coalition, they added nothing of importance.

4.4 RESULTS: REVIEW OF MEASURES

Having reviewed the 68 papers for measures of the constituent elements of social inclusion, we obtained, from published, web and personal contacts all of the relevant instruments. The next section presents a brief review of the 10 measures that were identified. In this section we are concerned to (a) assess the coverage of the concept (b) the prior use of the measure and (c) whether its psychometric properties have been published. As the reader can tell from Appendix 2, the number of measures reporting satisfactory psychometric properties is very limited indeed.

NDT Review of measure of social inclusion (Bates 2005)

Bates also makes the distinction between the individual sense of inclusion and the government’s definition of it. He developed a series of key indicators (partly based on work by the Inclusion research Network with subsequent additions) and these are:

- Access to specific services – empowerment; participation; employed within
- Standard of living – income, housing, employment, education, healthcare
- Relationships – social networks; social capital, respect and positive attitudes of others

The questions in these areas are also mostly copied from established surveys, as in the SCOPE measure. Only 11 questions are used, compared to 12 pages in SCOPE. As Bates points out (as did several of the concept mapping groups) the answers to these questions do not give a sense of their personal meaning to the respondent, and ignore the fact that any individual may choose not to interact with family members for example. He also reminds us that ethnicity and gender are powerful determinants of the experience of exclusion and inclusion, and from the concept mapping results in the present study we should add age to that list. He provides a
useful summary of existing instruments and the domains that they cover under the headings demographics, social roles, and relationships/psychological. Each of the measures has been assessed using a standard review form, but it is not clear how the list of measures was drawn up in the first place.

Conclusion: Bates has undertaken extensive and valuable work on the extent to which services meet inclusion criteria, but this is beyond the scope of the present study. Nevertheless, it does mean that there is a tool available for making assessments of service provision against these criteria.

MIND SW (Williamson and Allen 2006)
From MIND SW comes an assessment based on ‘The Human Givens’. These are: Safe and secure; Give and receive attention; Independence and control; Emotionally connected to others; Part of a wider community; Friendship and intimacy; Sense of status within social groups; Sense of competence and achievement; Meaning and purpose; Physical health; Spirituality; Creativity; and finance. It is a measure for use in mental health services and defines mental health as ‘the capacity to think, feel and act in ways that lead to fulfilling relationships and a sense of well being’ making it an exclusively subjective measure. Under each heading the respondent completes boxes with statements in respect of (eg safety) things that make me feel safe; all you feel you have on a good day; what happens on a bad day; and how you would like to find ways of meeting this need. The respondent then gives a score out of 10 to represent how well he or she thinks they meet this need.

Conclusion: The tool will have all the strengths and weaknesses of a goal attainment schedule, ie while it is highly personalised, it makes direct and meaningful comparison between individuals or group aggregation (except for the score out of 10) more or less impossible.

Developing Valued Lifestyles Support Needs Pack (Davis and Lindley 1999)
This measurement tool is also designed for use in mental health services to determine the type and level of support any individual might require. The domains are: living in the neighbourhood; Getting involved in the community; Making own decisions; Being respected; Building on strengths; Money matters; Health and fitness; Peace of mind; Educational aspirations; and work inclusion. Under each heading are about 20 statements (eg find places with local social life) rated on a 7 point scale from ‘no help’ to ‘a great deal of help’, and a free form section to put three major choices of help topic. This is to help staff help the person meet these goals, and so is not unlike the MINDSW measure in this respect. All of the domains emerged in the present concept mapping exercise.

Conclusion: It is not clear how Davis and Lindley arrived at the domains or the statements, but this is about to be published. However obtained, the concept mapping exercise provide some post-hoc validation for the choice of domains, or vice versa!! . It is primarily of potential value in service
settings to monitor progress regarding inclusion and normalisation perhaps.

Anglia Ruskin/ UCLan (Secker 2006)
This instrument was based on a review, beginning with the Social Exclusion Unit report, adding published and unpublished literature, including service user contributions from web-sites of the major mental health charities. Instruments were also sought from arts and mental health projects in England, and questions sought from labour force and household surveys. Concepts arising in these materials were mapped against previously used questions by one member of the team followed by team discussion to include, exclude or adapt the questions. Where no questions addressing concepts were found new ones were created through discussion with the whole team, which includes two former service users.

The resulting 22 questions were grouped into the following categories: building social capital (6 items); social acceptance (5 items); neighbourhood cohesion (2 items); stability of housing tenure (2 items); engagement in leisure and cultural activities (3 items); and citizenship (4 items). Initially there were Likert rated but following piloting with 15 participants from arts and mental health projects, changed to a four point scale (not at all to yes definitely). 90 participants from 22 schemes completed the scale (88 answered over 90% of the questions and the other two less than one-third and so were removed). Data reduction techniques resulted in a 19 item measure, covering social isolation, social relations and social acceptance. Activity items, such as participating in a sport or helping a charity had low alpha coefficients and so were removed.

The remaining items are all largely subjective (eg I feel terribly alone and isolated; I have felt unsafe to walk in the neighbourhood; I have felt accepted by neighbours).

Conclusion: As the authors indicate it is not known whether the whole construct can be represented by these dimensions, and as the results of the concept mapping in the present study suggest, these dimensions are confined to individual and subjective, almost exclusively participatory or emotional aspects of inclusion. It may therefore be very suitable for use in a limited range of settings, but may be less comprehensive and useful in large scale studies requiring sophisticated analysis of multiple indicators.

Perceived community cohesion (Lev-Wiesel, 2003)
A number of researchers who represent the subjective approach to cohesion have proposed theoretical definitions and, despite the use of some different elements, share a common core meaning. Gross and Martin (1952) suggest that ‘perceived cohesion’ is the ‘sticking togetherness’ of the group, which later Hetcher (1987) and Bhattacharyya (1995) refer to as ‘solidarity’ (a deeply shared identity and shared values). Bollen and Hoyle (1990) define perceived cohesion as an individual’s sense of belonging to a particular group and his/her feelings of morale associated with membership of the group. A sense of belonging comprises cognitive and affective elements. Others substitute the term ‘perceived cohesion’ by the term ‘psychological sense of community’ (Unger and Wandersman, 1985; Gruber and Shelton, 1987; Buckner, 1988). McMillan and Chavis (1986) propose four elements of a
psychological sense of community: • membership (a feeling of belonging); • influence (the power of member and community to affect each other); • sharing values (fulfillment of an individual’s values by a community); and • a shared emotional connection (based on a common history). Findings are reported for a sample of 215 residents (77 men and 138 women) of three different communities according to their social–economic structure: kibbutz (n=39), village (n=76), and urban centre (n=100).

The questionnaire consisted of six parts (67 items) according to the elements constituting ‘perceived community cohesion’. A sense of belonging was addressed by 19 items (e.g. community members can count on me, I feel a part of the community). Social ties measures of the quality and quantity of social interaction were addressed by 5 items (e.g. I would like to have more friends in my community, I would like to meet community members more often). Perceived social support to measure individual belief in potential social support had 13 items (e.g. I feel responsible for my neighbours, I share my feelings and thoughts with my neighbours). Solidarity measures the feeling of togetherness and had 11 items (e.g. a member in trouble should turn to help to the leaders in our community, I contribute some of my time to help achieve community goals). Nine items related to rootedness measured a sense of place (e.g. I can’t see myself living in another place, I would like my children to live here when they grow up). Finally, 10 items measured feelings of alienation in a given community (e.g. the relationships among members of this community get worse, you cannot trust anyone in this community). Participants were asked to complete 4-point scales to describe their own feelings, with response options ranging from ‘total agreement’ (4) to ‘total disagreement’ (1). Reliability was .87 (Cronbach alpha). To examine the extent to which the element measures (sense of belonging, social ties, social support, rootedness, solidarity and alienation) serve as potential indicators of ‘perceived community cohesion’ elements, a Confirmatory Factor Analysis (CFA) was performed. The minimal loading factor that had been set by the authors was 0.40, therefore 15 items were dropped out of the questionnaire. The final questionnaire consists of 16 items that examined a sense of belonging, 7 items that examined alienation, 9 items that examined solidarity, 7 items that examined social support, 8 items that examined rootedness, and 5 items that examined social ties.

Conclusion: The weakness of this research seems to derive from the fact that the elements were highly inter-correlated. This may be an indication that in reality they cannot be differentiated entirely and so it is not certain exactly what is being measured and no comparative measures were used.

De Jong Gierveld and van Tilburg (2006)
Loneliness is an indicator of social well-being and pertains to the feeling of missing an intimate relationship (emotional loneliness) or missing a wider social network (social loneliness). The 11-item De Jong Gierveld Loneliness Scale has proved to be a valid and reliable measurement instrument for overall, emotional, and social loneliness, although its length has sometimes rendered it difficult to use in large surveys. In this study, the authors empirically tested a shortened version of the scale on data from two surveys (N = 9,448). Confirmatory factor analyses confirmed the
specification of two latent factors. Congruent validity and the relationship with determinants (partner status, health) proved to be optimal. The 6-item De Jong Gierveld Loneliness Scale is a reliable and valid measurement instrument for overall, emotional, and social loneliness that is suitable for large surveys. The α coefficients for the 6-item loneliness scale varied between .70 and .76 for the total adult population, indicating a quite reliable scale. As expected, the reliability coefficients for the 3-item emotional loneliness scale were lower, varying between .67 and .74.

It is unknown whether the functioning of the shortened 6-item loneliness scale, without the other 5 items, differs from the functioning of the 6-item scale when it forms part of the 11-item loneliness scale. This study has also shown that the 6-item loneliness scale and the 3-item emotional and social subscales of loneliness are good measuring instruments for the broad age range of adults (18 to 99 years), as well as for the three age subgroups investigated: those aged under 45 years, those aged 45 to 64 years, and those aged 65 years and over.

Conclusion: Some of the scales have moderate alphas, and it does not appear to have been widely used. It is doubtful whether it can form a constituent part of a social inclusion measure since it reflects the absence of relationship and wider networks. It is not clear whether the obverse of the loneliness score actually constitutes an inclusion index. Also, the items seem to be mood related and the authors do not seem to have explored the relationship with depressed mood, which might explain some of the variance of the measure. These objections seem sufficiently substantial not to warrant examination of the other major US loneliness measure (Russell, Daniel W., L. Anne Peplau, and Carolyn E. Cutrona. 1980. “The Revised UCLA Loneliness Scale: Concurrent and Discriminant Validity Evidence.” *Journal of Personality and Social Psychology* 39:472-80).

**The Participation Scale (Van Brakel et al 2006)**

A measure of participation, developed in Nepal, India and Brazil using standard methods. The instrument was based on the Participation domains of the International Classification of Functioning, Disability and Health (ICF), and assesses client-perceived participation. The participation domains of the ICF are: Learning and applying knowledge; General tasks and demands; Communication; Mobility; Self-care; Domestic life; Interpersonal interactions and relationships; Major life areas and Community; Social and Civic life.

Respondents rated their participation in comparison with a ‘peer’, defined as ‘someone similar to the respondent in all respects except for the disease or disability’. An 18-item instrument was developed in seven languages. Crohnbach’s a was 0.92, intra-tester stability 0.83 and inter-tester reliability 0.80. Discrimination between controls and clients was good at a Participation Score threshold of 12. Responsiveness after a ‘life change’ was according to expectation. Each centre was to aim to enrol 90 subjects. Thirty were re-interviewed to test inter-interviewer reliability, 30 to test interviewer stability over a period of 1 month. The remaining 30 were interviewed by the expert and also had a Participation Scale interview. Fifteen of these were to be re-assessed after 9 – 12 months to evaluate the dynamicity of the scale. Of these, 10 were to be subjects
expected to experience a major life change in this period (e.g., clients who were to receive major rehabilitation assistance) and five were to be controls. In addition, each centre interviewed 10 control subjects without leprosy, disability or other significant health condition. As no other validated participation assessment tool validated existed, the results were validated against the opinion of an expert – someone considered able to assess the severity of participation restrictions based on an interview. The experts rated the severity of participation restrictions on a 1 – 5 scale (1=none, 5=complete restriction).

Results
Number of scale items 18
Response scale weighting 0=no restriction, 1=some restriction, but no problem, 2=small problem, 3=medium problem and 5=large problem

Internal consistency
Item to total correlation Range of R: 0.32 – 0.73
Cronbach’s a 0.92
Factor analysis First factor=90% of variability (n=497)

External validity
Expert score R=0.44 (n=227, P=0.005, Spearman)
EHF score R=0.39 (n=724, P50.001, Spearman)
Self-assessment (n=496, P50.001, Kruskal –Wallis test)
Inter-interviewer reliability 0.80 (n=296)
Intra-interviewer reliability (stability) 0.83 (n=210)
Discrimination (median score (range)) Matched pairs (n=171)
Clients 13 (0 – 72; 95th percentile 50)
Control 2 (0 – 44; 95th percentile 12)

The psychometric properties of the Participation Scale have been extensively field-tested in six major languages in Nepal, India and Brazil according to a rigorous scientific protocol. The participation score was shown to be responsive to changes in participation following important events in people’s lives. The scale can be administered, on average, in less than 20 minutes. Beta-testing of the utility of the scale under routine work conditions was performed in 14 institutions and departments not involved in the development work. The feedback was very encouraging and indicated that the scale could fulfill a useful role in the rehabilitation of people with a variety of health conditions.

Conclusion: The Participation Scale may be used as an evaluation and research tool to study participation (restrictions) and the effects of programmes to promote social inclusion. It might therefore form a component part of a social inclusion measure, or it might be used to validate the participation component of a new index. Its use may be limited because of the way in which the ratings are not made against an objective standard but against the individual’s perceived peers. It is also problem oriented so is negatively (how much of a problem is this) rather than positively construed. However its psychometric properties seem to be
good. It does not appear to have been tested outside of the countries that developed it.

Lelieveldt (2004)
The data on the relationship between social capital and neighborhood-oriented forms of participation are derived from two surveys that were conducted in the spring of 2002 and 2003, in these three OBAZ neighborhoods (De Laares, Velve-Lindenhof, and Bothoven) that were offered 3.5 million guilders to improve the neighbourhoods, and three other neighborhoods (Pathmos, Twekkelerveld, and Deppenbroek) that were not. In 2002, 246 community respondents were drawn at random, which led to 144 completed interviews (response rate 58.5%), whereas in 2003, 336 addresses were drawn, which resulted in 163 completed interviews (response rate 48.5%). The empirical analysis was based on the combined total of 307 respondents. A neighborliness scale was been constructed on the basis of six items, including (borrowed tools, talked about personal problems, helped each other, and quarreled) and had an alpha = .79. In the survey, attitudinal social capital was measured using a battery of seven items with statements about respondents’ own attitude toward the neighborhood as well their perceptions of the attitudes of fellow residents. Neighborhood residents were asked how often they kept an eye on children playing outside, kept an eye on neighbors’ homes, complained to people displaying annoying behavior or put up a note with such complaints, removed dirt from the streets and, finally, how often they maintained public gardens or their own street side garden. The six items yield a scale with a minimum of 0 (never) and a maximum of 3 (often) (alpha = .64) (which is not very good). A second indicator of participation is based on an inventory of six categories of problems that respondents may have experienced and a simple, yes-or no, follow-up question that asked whether the respondent has tried to do something about the problem. The broad formulation of the follow-up question—“doing something in response to a problem”—captures all kinds of participation, from directly approaching the person who caused a problem to more indirect forms like contacting the police or civil servants. The third form of participation consists of voting at the latest municipal elections and has been included as a proxy for all kinds of institutionalized forms of political participation.

The structural dimension of social capital as measured by neighborliness has the biggest and most consistent impact on participation (although the way these are measured suggests that they are probably confounded), followed by sense of duty and finally by trust, which turns out to be non-significant for informal governance and negatively related to the conversion of problems into action.

Conclusion: the internal consistency of some scales is poor, and the results may have been achieved because different measures may have been confounded. Presents some interesting ideas about participation activity, but only uses voting for civic engagement. Probably too limited to be useful.
The Impact on Participation and Autonomy Questionnaire (IPA) (Sibley et al 2006)
As the title of this measure implies it is concerned with the assessment of the impact of disability, illness and handicap on autonomy and participation. It is doubtful therefore how relevant the measure would be in a general population context. The authors, in Nottingham and Southampton aimed to evaluate the validity and reliability of an English version of the Impact on Participation and Autonomy Questionnaire (IPA). The original Dutch IPA has been shown to load onto five factors. Subjects were 213 Two hundred and thirteen people with multiple sclerosis, rheumatoid arthritis, spinal cord injury, and general practice attendees, stratified by level of disability (median age 54, 42% male, 58% female). Self- and interviewer-administered outcome measures. Other measures: Short Form-36 Health Survey (SF-36), London Handicap Scale, three domains of the Functional Limitations Profile (FLP): household management, social integration, emotion.

Respondents are asked to ‘rate their chances of...’ for instance ‘getting around in my house when I want’; ‘visiting relatives and friends when I want’; going on the sort of trips and holidays I want to; getting washed and dressed the way I wish’ as very good, good, fair, poor and very poor.

The scale has good psychometric properties. Confirmatory factor analysis confirmed the construct validity of the IPA (Normal Fit Index>0.98, Comparative Fit Index>0.99), indicating a good fit to the model. Convergent and discriminant validity were confirmed by the predicted associations, or lack of, with the exception of a poor association between the ‘social life/relationships’ IPA subscale and FLP-emotion. Internal reliability of the IPA was confirmed (Cronbach alphas >0.8; item-total correlations for all subscales>0.5). Test-retest reliability was confirmed for all items (weighted kappas >0.6) and subscales (intraclass correlation coefficients >0.90). The authors suggest that further research is required to examine the responsiveness of the IPA to change over time, its clinical utility and suitability for use with people from ethnic minorities and with older people.

Conclusion: The five factors are (a) autonomy indoors; (b) family role; (c) autonomy outdoors; and (d) social life and relationships. (e) work and education. However the questions are much more focused on the former than the latter (15 items in a and b) money and leisure only 1 each relationships (7) work and education (6) Alphas are highest for indoor and outdoor autonomy. This suggests that this measure is more useful where the focus on handicaps and limitations to autonomy and participation – but even so participation is not actually assessed in much detail.

SCOPE (Huxley 2006)
The first measure addresses ‘aspects of’ inclusion and is very much determined by the need to capture objective indicators of inclusion and exclusion, as well as tapping subjective responses. The questions are based upon or derived directly from questions used in census and other representative household surveys, so that groups can be compared with local normative data from survey reports.
The domains in this measure are: leisure and participation, including volunteering; housing and accommodation; safety; work; finance; education and training; health; family and social life. There is a field trial of version 1 in operation, but no results or psychometrics at the time of the present report.

Conclusion: Does attempt both social indicator and subjective styles, but too soon to say if this will be successful. Requires further development and research.
5 DISCUSSION

5.1 CONCEPT MAPPING DISCUSSION

Our concept mapping groups spent a good deal of time identifying and then discussing specifically excluded groups, in particular as one might expect at the present time, migrant workers and religious groups, Islamophobia and ageism. Some groups saw the struggle to achieve a valued diverse society (celebrating difference) as a continual process, which is dynamic, and has shifting focus over time. “The most inclusive society is the one that respects and values diversity”. Interestingly, this concept was put forward by the largely BME group. The general population group made the point that you can be included in smaller, closer family or peer groups, yet at the same time excluded from the mainstream. Equally, as Atkinson is reported to have said ‘unemployment may cause social exclusion, but employment does not ensure social inclusion’ and also that unemployment does not necessarily lead to poverty where social protection is well-designed and employment does not always guarantee escape from poverty (Atkinson et al 2002, p.137). Burchardt et al (1999) report that their analysis of data from 1991 to 1995 show that there is no distinct group of socially excluded individuals: few are excluded on all dimensions in any one year & even fewer experience multiple exclusion for the whole period.

There was a recognition in the groups that discrimination and stigma, arising in the general population was a major cause of the exclusion of certain groups and individuals, and that the converse, acceptance, tolerance, trust, respect, understanding, and valuing diversity were necessary factors in achieving inclusion. These values are manifest in interpersonal behaviours necessary for the achievement of inclusion, but do not represent inclusion in themselves? Service users and professionals were particularly likely to mention the need to be treated with respect, having choice and a say when accessing services (see map 9).

In many groups the achievement of social inclusion was identified with certain states of health or mind, or well-being such as fulfilment, purpose, confidence, freedom, identity, individuality, power, control, self-esteem and so on. Presumably these are states that are achieved at the end point of the process of inclusion, but are not entirely synonymous with the ‘included’ state. There was a suggestion that these things followed from being ‘engaged’ in society, and that participation led to them. Having a meaningful social role and empowerment were both thought to lead to the same state(s).

Concepts such as acceptance and confidence are largely emotional and subjective responses or outcomes of the process of exclusion or inclusion. Do we need to retain the distinction between social inclusion and its emotional impacts? Denial of rights, or restricted opportunities to participate presumably can have the same personal, cognitive, behavioural and emotional consequences for the excluded person(s), and both can be construed as limitations upon full citizenship. Many of the constructs that our concept mapping groups considered were the effects
or the goals of social inclusion, rather than social inclusion or exclusion per se. This matters for measurement considerations. The former are almost exclusively subjective and reflect feeling-states (perceived inclusion), the results of the behaviours of others towards the person or the results of restricted opportunities, whereas the latter are objective and reflect observable facts about social status, social actions and social position, (observed inclusion) therefore different measurement methodologies, or at least different types of interrogation are required.

5.2 DISCUSSION: REVIEW OF THE LITERATURE AND MEASURES

Individual level – perceived inclusion

Attempts to measure social inclusion fall into two broad methodologies which might be crudely characterized as individual level and societal level measures (these are observed quite strikingly in MAP 2). Berman and Phillips (2000) regard both of these as part of social indicator measurement. However, it seems to be increasingly the case that the content of individual measure are, and should be, determined by excluded groups themselves, such as mental health service users or disabled people generally. Societal level measures, or regionally aggregated indicators, on the other hand tend to be selected by ‘experts’ or bureaucrats rather than excluded groups (CIARIS 2006).

Individual level measures, usually address ‘perceived’ inclusion or exclusion; social inclusion evaluations of services may use these data in aggregated form. Examples would be the 10-item Interpersonal Support Evaluation List (Cohen, Mermelstein, Kamarck, & Hoberman, 1985), the nine-item Inclusionary Status Scale (Spivey, 1990) or the two-dimensional social interaction scale (Tse and Bond, 2001).

The Roeher Institute in Canada represents the perceptions of disabled persons, and therefore their views are likely to resonate with our concept mapping groups which have members with mental health problems or professionals working from the same social model of disability. Crawford (2003) suggests that two key themes emerge from this perspective. People with disabilities want to be socially included in the sense that they, like others, want:

- To participate as valued, appreciated equals in the social, economic, political and cultural life of the community (i.e., in valued societal situations) and
- To be involved in mutually trusting, appreciative and respectful interpersonal relationships at the family, peer and community levels.

That is, people want inclusion in the situations that most people take for granted and want to be welcomed and valued, there. (Similar findings in respect of people with mental health problems are reported in Evans and Huxley 2005).
Crawford (2003) lists the socially valued situations that people want to participate in as:

- Early childhood development opportunities.
- Good quality regular elementary and secondary education with age peers.
- Post-secondary education or training.
- A job or career and income security in the event of unemployment.
- An affordable, healthy and pleasant home that meets individual and family needs.
- A safe, secure, healthy and pleasant neighbourhood.
- Justice in the event of violence or abuse.
- Recreational opportunities and chances for cultural/artistic expression.
- Shops, places of commerce and other consumer options.
- Health, social and related services.
- Clubs, faith communities, voluntary associations. The Internet or "information highway" more broadly.
- Opportunities/venues for civic involvement (e.g., through public, private or voluntary sector governance arrangements; social and economic development processes; social justice or charitable causes, etc.).
- Partnerships with like-minded people working for common purposes.
- The political process.

Valued interpersonal situations in which people want to participate include:

- Family, a variety of friendships and relationships with trusted, respectful others in the community.

Again, as you can see below, these are all reflected in the concept mapping group discussions. Any index based on individual measures would need to reflect these socially valued situations.

Crawford goes on to argue that certain essential conditions need to be in place in order for people to achieve inclusion, these are:

"first, people need to be in or have access to those situations in the first place - the access dimension. For instance, a labour market that includes people of colour, Aboriginal persons and people with disabilities in employment at the level of employment for society taken as a whole. Second, once in a given situation, people also need to have the practical means necessary to participate as appreciated, valued equals - the support dimension. For example, it may be that a school is accessible in terms of the basic 'head counts' of children with disabilities in relation to other children. However, the school may be making little or no provision to ensure that children with disabilities are in regular classrooms with the human, instructional, technological and material supports needed for effective learning with their age peers".
As indicated earlier, both access and support feature consistently in the concept mapping group discussions, but again perhaps more in the service user and professional dominated groups.

**Societal level – social indicators**
The second major approach to the measurement of inclusion is the social indicators approach which uses existing (statistical) data sources in an aggregated form to assess the success or change, in social inclusion terms, of various policies and strategies. These policies are often area-based, for example the ‘Social Inclusion Measure’ groups in the Irish Republic’s regions, or may relate to more local services, for example schools in Hampshire. Bates’s measure of socially inclusive mental health services (see above) falls into this category. Existing indicators are taken to represent aspects of inclusion, and these may be aggregated into a single index. The characteristics of good quality social indicators have been outlined by Atkinson et al (2002) and any social inclusion index would have to reflect these principles. As Atkinson indicates (p20) the aim is to measure social outcomes, not the means by which they are achieved. Each indicator should:-

- identify the essence of the problem and have a clear and accepted normative interpretation
- be robust and statistically validated
- be responsive to effective policy interventions but not subject to manipulation
- be measurable in comparable ways in different societies
- be timely and susceptible to revision
- not impose too great a burden of measurement

In addition, the whole portfolio of indicators should conform to the following principles:

- the portfolio of indicators should be balanced across dimensions (or domains)
- they should be mutually consistent and proportionate
- transparent and accessible to the general population

Berman and Phillips (2000) present a number of indicators of social inclusion along these lines. Inclusion in the social security system can be measured by: the distribution of access to social security services; low income by demographic variables; (age, sex, region, ethnicity, employment status etc.); labour market inclusion by the distribution of discrimination in access to jobs, full-time and part-time employment etc; housing market inclusion by the distribution of access to neighbourhoods, subsidised and protected housing; homelessness etc; and health service coverage by the distribution of access to health services; mortality etc; inclusion in the education system and services by the distribution of access to and discrimination in educational and cultural services; political inclusion by the franchise, restrictions on eligibility to stand as an elected representative or member of a government7; inclusion in community by the distribution of access to leisure facilities and neighbourhood services; and social status inclusion by equal opportunities and anti-discrimination legislation and the distribution of access to social and leisure facilities.
Atkinson et al (2004) update the indicators in use by the EU in respect of social inclusion and in a new book examine the challenges in their use (Merlier et al 2006). Room (2005) has pointed out that these indicators, slightly modified, have then been used in the second round of national action plans (European Council, 2004, Section 10).

In the UK, the Cabinet Office commissioned Levitas and colleagues to explore the extent to which existing sources of social indicators and administrative data could be used to capture the present state of social exclusion. They report 11 different definitions of exclusion but only one of social inclusion. After producing their own composite definition, Levitas et al created the Bristol Social Exclusion Matrix, which has three major sections: resources (material, access to services, social resources); participation (economic, social, culture education and skills, political and civic); and quality of life (health and well-being, living environment, crime, harm and criminalization). They examined 27 potential sources of data and selected the best for data on children, adults of working age and older people. These were: the Millennium poverty and social exclusion survey; the families and young children survey; the longitudinal survey of young people (ALSPAC); the British household panel survey and the General Household Survey for adults of working age; and the English Longitudinal Study of Ageing (ELSA) for older groups.

There is often no link at all between the two major types of measurement approach, and the Laidlaw Foundation's observation (2006) - that the social indicator approach misses out on the meaning of inclusion to individuals - leads them to suggest the need to also use subjective indicators – which ironically repeats the 1960s debate in the UK started by Mark Abrams, and a similar experience in the USA about 30 years ago. Berman and Phillips (2000) note that “there seems to be an obvious scope for widening the use of subjective indicators within the social quality elements and indeed holistic subjective indicators for the empowerment and social inclusion as a whole could be powerful additions to measuring aspects of social quality.” (p.336). Among the remaining methodological issues, therefore, is whether the two major approaches to the measurement of social inclusion have to remain separate, or whether there is a way of bringing them together in a single index.

**A combined approach?**
A single index based on the two methodologies may prove to be impossible given the very different purposes for which the methods appear to have been developed. Another important consideration, therefore, is the use to which any indicator is to be put, as Atkinson says ‘our aim is to propose indicators for a particular purpose’ (2002; p21). There are many different reasons to measure social inclusion, and it may be that it is not possible to use a social inclusion measure that has not been designed with that particular purpose in mind. In one of the early meetings of the expert group the following different purposes of social inclusion measures were identified (with acknowledgement to David Morris) (Table 4).
Table 4: Purposes and sought effects of a social inclusion index

<table>
<thead>
<tr>
<th>Domain</th>
<th>Policy</th>
<th>Theory</th>
<th>Practice</th>
<th>Research</th>
<th>Evaluation</th>
<th>Real life/personal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sought effects (after Hills 2002)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention (stopping people becoming excluded)</td>
<td>Impact or influence of</td>
<td>Predictive</td>
<td>Outcome</td>
<td>Efficacy</td>
<td>Effectiveness</td>
<td>Impact</td>
</tr>
<tr>
<td>Promotion (helping people to exit)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protection (from the worst effects of being excluded)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Propulsion (ensuring that having exited you don’t return)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In terms of the societal and individual distinction, the purposes of policy are perhaps best served by social indicators and the real life impacts and implications by individual subjective measures. Sheldon and Land (1972) pointed out that indicators can be policy orientated, but also descriptive of social trends and changes, and analytic, serving as elements of conceptual or causal models of social systems (column 2 in the table above). In between however, a mixture of both approaches might prove most beneficial. In theory, assuming the distinctions are sustainable and useful, the matrix could be populated with different inclusion measures, but some designed for one purpose may prove unfit or unacceptable for another. For instance, brief measures, suitable for use by service providers may be useful for clinical purposes and acceptable to staff and service users, but be very limited in scope and depth for research purposes. They may also have a limited capacity to show change over time. Social indicators that provide policy makers with useful data, might conversely, appear remote and irrelevant to many service providers and users. This may be especially the case where social indicators are aggregated at area level for policy and planning purposes. Many social indicators appear to be chosen on the basis of opinion, usually of the authors (policymakers or academics); Keuning and Verbruggen (2003) describe the result as a situation in which "indicators have been designed that do not measure what they intend to measure, are based on incomparable data and give the impression of a fairly incoherent shopping list of numbers without an underlying vision on the use of these numbers in policy making" (p197).
On the basis of their work for the Cabinet Office, Levitas (2006) and colleagues conclude that it is not possible to produce a single composite score representing exclusion, and that the three categories of resources, participation and quality of life need to be retained as separate domain indicators. Our view is that quality of life as they have conceived it does not constitute part of the measurement of social inclusion, but that subjective responses in the resources and participation domains is an appropriate part of a social inclusion measure. Should we say here that we see QOL as the big picture and social inclusion as only one part of that.

We can see that the rights and participation issues from the review by Burchard et al do figure in these groups, but the latter features more than the former. Most groups identified the material circumstances and social structural variables also observed in the review.

If we take, for example the social exclusion work of Levitas (2006), and the Berger-Schmitt and Noll inclusion work we can see that the structures are very similar, and that in most cases, most of the concept mapping groups identified the same components (Table 5 below)

<table>
<thead>
<tr>
<th>Table 5: Domains of social inclusion by different methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berger Schmitt &amp; Noll</td>
</tr>
<tr>
<td>Household and families</td>
</tr>
<tr>
<td>Labour market and working conditions</td>
</tr>
<tr>
<td>Income, standard of living, consumption patterns</td>
</tr>
<tr>
<td>Social, political participation</td>
</tr>
<tr>
<td>Environment</td>
</tr>
<tr>
<td>Social Security</td>
</tr>
<tr>
<td>Public safety and crime</td>
</tr>
<tr>
<td>Housing</td>
</tr>
<tr>
<td>Transport</td>
</tr>
<tr>
<td>Leisure, media, culture</td>
</tr>
<tr>
<td>Health</td>
</tr>
<tr>
<td>Education and vocational training</td>
</tr>
</tbody>
</table>
6 CONCLUSIONS

6.1 SOCIAL INCLUSION MEASUREMENT

- There are two broad approaches to the measurement of social inclusion (a) social indicators of inclusion and (b) perceived inclusion measures.

- Each approach may be more suited to some purposes than others, with administrative data or survey indicators being more useful for the assessment of policy impact or performance management.

- For other purposes, such as clinical ones, subjective measures may be more useful and informative at the individual level.

- It may be that for other purposes some combination of both approaches might be valuable and acceptable, but this has not been tested to date.

- On the basis of our review of the evidence we suggest that any proposed social inclusion index should focus on the availability of opportunity to access material and other resources, and the subjective view of this availability. It should address the extent to which the person participates in these life activities, and also the person’s subjective perception of the value or benefit of these activities for themselves. It should also assess the degree to which the person wishes to have more or less or the same level or type of participation in each life domain, otherwise it is not possible to encompass the feelings of those who are satisfied with what might be a low level (personally and normatively) of activity through choice. Making this last assessment is also helpful in quantifying the extent of resignation and aspiration, enabling response shift to be detected (Evans and Huxley 2005).

- It may also be possible to incorporate individual goals under this last heading/column. In this way any idiosyncratic/personalised inclusion life goals could be located within a more structured and standardised framework than is usual with goal attainment scaling. The type of questions to be asked in this section of the index would be like those asked on the MIND-SW and Davis clinical tools, or in the rights based version, the wish for improved entitlements. The options here would be to incorporate these or other measures, or alternatively generate a new set for each of the domains.

- This approach is synthesised in the following proposed social inclusion matrix which is based on the evidence we have gathered through the concept mapping exercises and reviews. We advocate the development of an index based on these domains, opportunity indicators and perceptions of access and participation.
<table>
<thead>
<tr>
<th>Domain content</th>
<th>Opportunity of access to material resources/existence of rights</th>
<th>Perceived access to resources/presence of entitlements</th>
<th>Participation/actual realisation of rights</th>
<th>Perceived participation/perceived realisation of rights</th>
<th>Choice/improved or changed entitlements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family activity</td>
<td>Family exists and participation possible</td>
<td>Perceived adequacy</td>
<td>Actual level of contact</td>
<td>Benefit/value</td>
<td>More/less/Same/different</td>
</tr>
<tr>
<td>Social activity</td>
<td>Opportunity exists for social participation</td>
<td>Perceived adequacy</td>
<td>Actual social contacts</td>
<td>Benefit/value</td>
<td>More/less/Same/different</td>
</tr>
<tr>
<td>Work</td>
<td>Economically active</td>
<td>Perceived availability</td>
<td>Level of activity</td>
<td>Benefit/value</td>
<td>More/less/Same/different</td>
</tr>
<tr>
<td>Income</td>
<td>Has income</td>
<td>Perceived adequacy</td>
<td>Level of income</td>
<td>Benefit/value</td>
<td>More/less/Same/different</td>
</tr>
<tr>
<td>Political &amp; civic</td>
<td>Access to civic opportunities</td>
<td>Perceived adequacy</td>
<td>Level of participation</td>
<td>Benefit/value</td>
<td>More/less/Same/different</td>
</tr>
<tr>
<td>Community facilities</td>
<td>Community facilities exist</td>
<td>Perceived adequacy</td>
<td>Use of facilities</td>
<td>Benefit/value</td>
<td>More/less/Same/different</td>
</tr>
<tr>
<td>Financial services</td>
<td>Access to financial services</td>
<td>Perceived adequacy</td>
<td>Use of services</td>
<td>Benefit/value</td>
<td>More/less/Same/different</td>
</tr>
<tr>
<td>Neighbourhood safety</td>
<td>Access to neighbourhood</td>
<td>Perceived adequacy</td>
<td>Actual activity levels</td>
<td>Benefit/value</td>
<td>More/less/Same/different</td>
</tr>
<tr>
<td>Housing quality</td>
<td>Access to adequate housing</td>
<td>Perceived adequacy</td>
<td>Actual quality</td>
<td>Benefit/value</td>
<td>More/less/Same/different</td>
</tr>
<tr>
<td>Transport</td>
<td>Actual availability</td>
<td>Perceived availability</td>
<td>Actual level of use</td>
<td>Benefit/value</td>
<td>More/less/Same/different</td>
</tr>
<tr>
<td>Leisure activities</td>
<td>Access to range of leisure activities</td>
<td>Perceived adequacy</td>
<td>Actual use</td>
<td>Benefit/value</td>
<td>More/less/Same/different</td>
</tr>
<tr>
<td>Mental health</td>
<td>Access to mental healthcare</td>
<td>Perceived adequacy</td>
<td>Actual use</td>
<td>Benefit/value</td>
<td>More/less/Same/different</td>
</tr>
<tr>
<td>Physical health</td>
<td>Access to physical healthcare</td>
<td>Perceived adequacy</td>
<td>Actual use</td>
<td>Benefit/value</td>
<td>More/less/Same/different</td>
</tr>
<tr>
<td>Educational attainment</td>
<td>Access to educational opportunities</td>
<td>Perceived adequacy</td>
<td>Actual use</td>
<td>Benefit/value</td>
<td>More/less/Same/different</td>
</tr>
</tbody>
</table>
6.2 THE WAY FORWARD – INDICATORS

There are several options here. One is to develop this aspect of the index in association with others who have already progressed this in some detail. However, there are several candidates who might provide appropriate questions. Some of these are indicated below and further details given in Appendix 3.

European Social Survey
GESIS - ZUMA
NPI/Rowntree

This would have the disadvantage that the questions are predetermined and may not be the most acceptable to service users. On the other hand this would permit both comparative and longitudinal research. It would require a sophisticated option appraisal to determine which is most suited to purpose.

Another option is to use data from the existing best surveys, which, for children, adults of working age and older people, have been identified by Levitas et al.

Another option, also proposed by Levitas (2006) is to incorporate a social inclusion module in the UKLHS or similar survey. This has the same disadvantage (predetermined questions) and also cannot be disaggregated at the local level or at the service level. As has been pointed out, household surveys tend to exclude the most excluded groups. This does not stop the normative levels of inclusion in households being seen by excluded groups as aspirational targets (to reach or go beyond the normative levels). On the other hand, as one group pointed out, there is a pressure to be included and to conform, that many people choose to resist.

A further option is to construct the indicators from administrative sources. Again, there are a number of options, for example, in the mental health context:

The National Minimum Data Set
The Mapping Project – Mental Health Strategies
or Local Authority data

Although these would allow regional, local and service area disaggregation, there are problems of data quality, completeness and accuracy, and only relates to the treated populations. There are also ethical issues about the use of these data when collected for other purposes. If the situation develops where local measures and methods are allowed to vary to suit local needs, then higher level aggregation becomes difficult or impossible.
6.3 THE WAY FORWARD – PERCEIVED INCLUSION

The Van Brakel et al. participation measure emerges as the best psychometrically, but using a comparison with peers may be a problem, and it appears not to have been used widely outside the countries that developed it. It is negatively oriented, which might make a difference to the results (see Sam Thompson, Centre for Well-being, nef, DH/CSIP 2006). It could be used to compare with a new measure.

The Davis measure is closest to the choice column/goal attainment scaling, and might therefore be the most acceptable measure for service users, although there would be some doubt that it would be as comprehensible to the general population; also the psychometrics are about to be reported.

Options here are very limited. There is no single, tested and sound measure of social inclusion that is an accepted standard measure. Measures of the component parts of a possible measure, such as access to material goods etc, and social and community participation, are available, but usually do not have adequate psychometrics, with the exception of the Van Brakel measure, and there are some reservations about its use. The instrument developed by Wilson et al, currently being applied in North Adelaide might prove to contain some useful scales, but the results have not been reported yet.

We are therefore left with the need to create a new index, as suggested in the original Phase 2 proposal. We think that it is worthwhile attempting a combined approach, rather than abandoning the indicator research to social scientists and abandoning the perceived inclusion research to clinicians. However, the indicator approach is clearly very well developed and likely to become more sophisticated and accessible on-line, so this research will continue whatever decision we make about a social inclusion index. One of the options for creating a social inclusion indicator index suggested above is almost certain to be adopted in the UK, and so indicators of social inclusion will be measured at the national, regional and possibly local level. On the other hand the perceived inclusion research lags a long way behind and so more research is certainly required in this area in order to arrive at a subjective measure or measures covering the relevant domains. Subjective well-being scales have been widely used in quality of life research and may well lend themselves to use in this context, and would correspond with column five in the matrix above. A number of domain ratings of this sort were included in the National Psychiatric Morbidity Survey, providing some comparative data.
6.4 IMPLICATIONS FOR PHASE II PROPOSAL

The psychometric testing of the instrument will follow the outline in our original proposal. However, there are some additional prior steps that would be required in order to populate a measure with specific questions.

First, on the assumption that the opportunity of access questions, and participation questions (and scaling) are those that are most likely to relate to existing indicator questions, it would be necessary to reach agreement about with indicator questions are the most fit for this purpose. Here, it would be important to work with existing indicator researchers to arrive at the best set, including their acceptability to excluded groups. One major purpose of this approach would be to show where a patient population is relative to the local or regional or national norms on the same items.

Second, a similar process to determine the best and most acceptable forms of words (to excluded groups and in general) for the subjective questions would be needed in each of the domains where indicators have been selected. Both sets of questions could be cognitively appraised. Instrument testing would follow the original plan. However, we now have some alternative tested measures, with reasonable psychometric properties against which, a new index could be compared for convergent and discriminant validity.

Different forms of the measure may be required. There are two options; different measures for young people, people of working age and older people as in the NPI work; or a common core measure with additional questions relevant to these groups. The concept mapping exercise gives us a beginning in identifying the different age-related concerns. Self-rated versions could be tested against interview versions.

Finally, in the interests of conceptual progress, we would suggest an experiment, possibly funded from other sources that would involve applying standard measures of the several related concepts referred to in the background section of this report, to a large population sample, across several localities, to see whether a latent analysis supports the discreteness of the constructs. This would also involve multi-level modelling to encompass the issues of individual and area level measurement. This would be something similar to the subjective measures paper we produced for Nervous and Mental Diseases on subjective ratings (Priebe et al 1999).


Chapin, S.F. (1924) Leadership and Group Activity, Sociology and Social Research 8:141-145.

Chapin, S.F. (1928) A quantitative scale for rating the home and social environment of middle-class families in an urban community: a first approximation to the measurement of socio-economic status, Journal of Educational Psychology 19:99-111.


EKOS (2005) Review of ESF Social Inclusion Measures: Final Report to the Scottish Office. EKOS, St George's Studios, 93-97 St George's Road, Glasgow, G3 6JA.


Lelkes, O. (2005) Knowing what is good for you: Empirical analysis of personal preferences and the 'objective good'. CASE discussion paper, LSE.


Eu reporting: Conceptual framework of the European System of Social Indicators

In its initial phase, research on developing the European System of Social Indicators was funded by the European Commission for a duration of 3 years as a subproject of the "EuReporting-Project" ("Towards a European System of Social Reporting and Welfare Measurement") within the 4th Framework TSER-Programme. The EuReporting-Project included scholars from 13 European countries. As part of this project, the theoretical framework as well as the basic architecture of the European System of Social Indicators has been developed.

The conceptual framework of the European System of Social Indicators is based on a reflection of the scientific discourse on notions of welfare and related goals of societal development. In addition, an inventory of the goals and objectives pursued by the policies of the European Union has been undertaken. From both types of analyses, the conclusion was drawn that there are six major perspectives and dimensions of societal development in Europe which ought to be addressed by the European System of Social Indicators and should be used to derive and select measurement dimensions and indicators. The goal and measurement dimensions considered reflect the essential notions of the concepts of quality of life, social cohesion, and sustainability.

The concept of quality of life incorporates two major dimensions:

- Objective Living Conditions: This dimension concerns the ascertainable living circumstances of individuals, such as working conditions, state of health or standard of living.
- Subjective Well-Being: This dimension covers perceptions, evaluations and appreciation of life and living conditions by the individual citizens. Examples are measures of satisfaction or happiness.

The two basic dimensions extracted from the concept of social cohesion are:

- Disparities, Inequalities and Social Exclusion: This dimension refers to aspects of the distribution of welfare within a society such as regional disparities, equality of opportunities for women and men or other population groups.
• Social Relations, Ties and Inclusion: This second dimension of social cohesion concerns the social relations, bonds and ties within a society or what has been denoted as ‘social capital’. The existence of informal networks, associations and organisations and the performance of societal institutions are issues addressed by this dimension of social cohesion. Moreover, the cohesion between and integration of European societies is also covered by this dimension.

Two other dimensions have been extracted from the concept of sustainability in its notion of the World Bank’s four-capital approach. According to this approach, sustainability means to preserve the societal capital (physical capital, social capital, human capital, natural capital) in order to secure equivalent living conditions for future generations:

• Preservation of Human Capital: Measurement dimensions and indicators related to this goal dimension focus on processes and measures that affect people’s skills, education and health.

• Preservation of Natural Capital: This dimension concerns the current state as well as processes and measures that improve or deteriorate the base of natural resources.

Besides these six goal dimensions concerning the quality of life and societies, the European System of Social Indicators also addresses selected trends of general social change in terms of

• Demographic and Socio-Economic Structures;

• Values and attitudes.

These eight major dimensions of welfare and general social change are being applied to the 13 life domains establishing the basic structure of the European System of Social Indicators. Thus, within each life domain up to eight dimensions of welfare and general social change are distinguished and operationalized in terms of domain-specific measurement dimensions, subdimensions and indicators. The 13 life domains are: population, households and families; housing; transport; leisure, media and culture; social and political participation and integration; education and vocational training; labour market and working conditions; income, standard of living and consumption patterns; health; environment; social security; crime and public safety; total life situation.
### Appendix 2: Papers selected for review and included or excluded

<table>
<thead>
<tr>
<th>Author</th>
<th>Journal &amp; year</th>
<th>Subject</th>
<th>Class</th>
<th>Comment (including psychometrics where available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aumack L</td>
<td>Journal of Clinical Psychology 18(4):436-441 (1962)</td>
<td>Social adjustment behaviour rating scale</td>
<td>3</td>
<td>Work level and socialization level measures, not inclusion; language dated</td>
</tr>
<tr>
<td>Berger-Schmitt R</td>
<td>Social Indicators Research 58(1-3):403-428</td>
<td>Social cohesion and quality of life</td>
<td>1</td>
<td>Not inclusion useful conceptually</td>
</tr>
<tr>
<td>Berger-Schmitt R and Noll H H</td>
<td>EU Reporting (2000)</td>
<td>Conceptual framework for EU social indicators</td>
<td>1</td>
<td>Very useful model</td>
</tr>
<tr>
<td>Berman Y and Philips D</td>
<td>Social indicators research 50:329-350 (2000)</td>
<td>EU social quality and exclusion measures</td>
<td>1</td>
<td>Useful conceptually</td>
</tr>
<tr>
<td>Boelhouwer J</td>
<td>Social Indicators Research 60:89-113 (2002)</td>
<td>Social indicators and the living conditions index (LCI)</td>
<td>1</td>
<td>Age, employment and single parents worse off; useful model</td>
</tr>
<tr>
<td>Brent Hall G &amp; Nelson G</td>
<td>Social Science and Medicine 43(12): 1743-1754 (1996)</td>
<td>Social networks, social support and personal empowerment</td>
<td>3</td>
<td>Related social support and networks to affect activity</td>
</tr>
<tr>
<td>Connerly CE &amp; Marans RW</td>
<td>Social Indicators research 17:29-47 (1985)</td>
<td>Perceived neighbourhood quality</td>
<td>3</td>
<td>Satisfaction and attachment to neighbourhood</td>
</tr>
<tr>
<td>Dale B</td>
<td>Regional Studies 14:503-515 (1980)</td>
<td>Subjective and objective social indicators, regional</td>
<td>3</td>
<td>Useful discussion of the relationship between O and S data but not a measure</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Title/Reference</td>
<td>Description</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>EKOS</td>
<td>EKOS, Glasgow, Final report to the Scottish Office (2005)</td>
<td>Review of ESF social inclusion measures</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Gelderblom et al</td>
<td>Technology and Disability 14 (3):113</td>
<td>Participation measure LIFE-H</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Gorard S &amp; Taylor C</td>
<td>Sociology 36(4):875-895</td>
<td>Segregation measures</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Hagerty B et al</td>
<td>Archives of Psychiatric Nursing 10(4):235-344</td>
<td>Sense of belonging</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Hong S &amp; Cho Y</td>
<td>Psychological Reports 84(3):1303-14</td>
<td>Social Interaction Self-statement Test</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Hooghe M</td>
<td>Nonprofit and Voluntary Sector</td>
<td>Participation in voluntary associations</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Journal/Publication Details</td>
<td>Title/Abstract</td>
<td>Page(s)</td>
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<td>---------------------------</td>
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<tr>
<td>Kafetsios K</td>
<td>Social Indicators Research 76(1): 127-145</td>
<td>Social support in Greece</td>
<td>3</td>
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<tr>
<td>Kempen G &amp; Van Eijk L</td>
<td>Social Indicators Research 35(3): 303</td>
<td>Social support</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Li Y et al</td>
<td>Sociological Research Online 8(4) (2003)</td>
<td>Social change, friendship and participation</td>
<td>1</td>
<td></td>
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<tr>
<td>Noll HH</td>
<td>Social Indicators Research 58: 47-87 (2002)</td>
<td>European social indicators</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Noreau et al</td>
<td>Disability and rehabilitation 26(6):</td>
<td>Measuring social participation using</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Journal/Publication Details</td>
<td>Measure/Schedule</td>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------------------</td>
<td>------------------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>Orth-Gomer K &amp; Unden AL</td>
<td>Social Science and Medicine, 24(1):83-94 (1987)</td>
<td>Measurement of social support in population studies</td>
<td>Reviews 17 measures but applied to n = 15 only. Divided into quantitative social network measures and adequacy of social support measures. Out of date?</td>
<td></td>
</tr>
<tr>
<td>Parker RN</td>
<td>American Sociological Review, 48, 6, Dec, 864-873 (1983)</td>
<td>Measurement of social participation</td>
<td>US measure, out of date? Confined to formal and informal activities on behalf of formal voluntary organizations; too narrow/limited for present purposes?</td>
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<tr>
<td>Ralph A et al</td>
<td>Journal of developmental Psychology 18 :71-86 (1997)</td>
<td>Peer interactions</td>
<td>Adolescent social interaction profile; restricted to adolescent primary school pupils</td>
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<tr>
<td>Sengstock MC</td>
<td>International Migration Review 1291):55-65 (1978)</td>
<td>Index of ethnic community participation</td>
<td>Ethnic group, intermarriage and location only variables used</td>
<td></td>
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<tr>
<td>Shannon GW * Nystuen JD</td>
<td>The Professional Geographer 23-28 (1976)</td>
<td>Surrogate measures of urban social interaction</td>
<td>Surrogate measures only</td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Journal</td>
<td>Year</td>
<td>Measure/Construct</td>
<td>Notes</td>
</tr>
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<tr>
<td>Sibley et al</td>
<td>Clinical rehabilitation 20(9): 793-803 (2006)</td>
<td>Impact on participation and autonomy questionnaire (IPA)</td>
<td>2</td>
<td>Dutch original, psychometrics good or moderate, may be too related to functioning?</td>
</tr>
<tr>
<td>Tanton R et al</td>
<td>NATSEM. Canberra</td>
<td>Children at risk of exclusion</td>
<td>3</td>
<td>Exclusion indicators for children</td>
</tr>
<tr>
<td>Trigg et al</td>
<td>Clinical rehabilitation 13:341-353 (1999)</td>
<td>Social reintegration; subjective index of physical and social outcome (SIPSO)</td>
<td>3</td>
<td>Stroke patients only, n=30, limited activities follow stroke</td>
</tr>
<tr>
<td>Tse WS &amp; Bond AJ</td>
<td>Psychiatry Research 103:249-260 (2001)</td>
<td>Two dimensional social interaction scale</td>
<td>3</td>
<td>For social functioning assessment by observation of participation type</td>
</tr>
<tr>
<td>Unden AL &amp; Orth-Gomer K</td>
<td>Social Science and Medicine 29(12):1387-1392 (1989)</td>
<td>Reduced version of the ISSI for population surveys</td>
<td>3</td>
<td>Measure social support</td>
</tr>
<tr>
<td>Van Brakel W et al</td>
<td>Disability and Rehabilitation 28(4):193-203 (2006)</td>
<td>Generic participation interview scale (no disease specific terms); covers participation in learning, communication, mobility, self care, domestic life, interpersonal interactions, major life areas, community social and civic life.</td>
<td>2</td>
<td>18 item scale developed in Nepal, India and Brazil (n=496)Alpha =0.92 Intra tester stability = 0.8 (n=296) inter tester reliability = 0.8, (n=210) good disc validity (n=171). Wider applicability?</td>
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<tr>
<td>Wieland</td>
<td>Forthcoming 2006</td>
<td>Distal support measure</td>
<td>3</td>
<td>Measure of distal support only</td>
</tr>
<tr>
<td>Wilson L</td>
<td>Social Indicators Research 75(3): 335- 360 (2006)</td>
<td>Model for measurement of social inclusion and capital in Australia</td>
<td>1</td>
<td>Useful background review; measure not included</td>
</tr>
<tr>
<td>Zappala G</td>
<td>The Smith Family Research Team (2003)</td>
<td>Barriers to participation among low income Australians</td>
<td>3</td>
<td>Social indicator frequencies; no advantage over the EU indicators</td>
</tr>
</tbody>
</table>

(*) 1 - Background only; 2 – Potential SI or component/related measure; 3 – Other concepts or irrelevant
Appendix 3

CANDIDATES FOR SOCIAL INDICATOR MEASURES OF SOCIAL INCLUSION

The International Social Survey Program (ISSP) is a continuing, annual program of cross-national collaboration.

Since 1984, ISSP has grown to 41 nations, the founding four--Germany, the United States, Great Britain, and Australia--plus Austria, Ireland, Hungary, the Netherlands, Israel, Norway, the Philippines, New Zealand, Russia, Japan, Bulgaria, Canada, the Czech Republic, Slovenia, Poland, Sweden, Spain, Cyprus, France, Portugal, Slovakia, Latvia, Chile, Denmark, Brazil, South Africa, Switzerland, Venezuela, Belgium, Finland, Mexico, Taiwan, South Korea, Uruguay, Croatia, the Dominican Republic and Turkey. In addition, East Germany was added to the German sample upon reunification. Some nations have replicated particular modules before being ISSP members (e.g. Poland, in 1987, and Switzerland, in 1987 and 1993).

The annual topics for ISSP are developed over several years by a sub-committee and pre-tested in various countries. The annual plenary meeting of ISSP then adopts the final questionnaire. The ISSP researchers especially concentrate on developing the questions that are 1) meaningful and relevant to all countries and 2) can be expressed in an equivalent manner in all relevant languages. The questionnaire is originally drafted in British English and then translated to other languages using standard back translation procedures.

ISSP marks several new departures in the area of cross-national research. First, the collaboration between organizations is not special or intermittent, but routine and continual. Second, while necessarily more circumscribed than collaboration dedicated solely to cross-national research on a single topic, ISSP makes cross-national research a basic part of the national research agenda of each participating country. Third, by combining a cross-time with a cross-national perspective, two powerful research designs are being used to study societal processes.

The European Social Survey (the ESS) is an academically-driven social survey designed to chart and explain the interaction between Europe's changing institutions and the attitudes, beliefs and behaviour patterns of its diverse populations. Now in its third round, the survey covers over 20 nations and employs the most rigorous methodologies. The fieldwork has been funded through the European Commission's fifth and sixth Framework Programme, the European Science Foundation and national funding bodies in each country. In addition the ESS is among the first social science projects to receive funding to support its infrastructure.
The project is directed by a Central Co-ordinating Team led by Roger Jowell at the Centre for Comparative Social Surveys, City University. The six other partners are -

- Bjorn Henrichsen at NSD Norway
- Ineke Stoop at SCP Netherlands
- Willem Saris at the University of Amsterdam
- Jaak Billiet at the University of Leuven
- Peter Mohler at ZUMA Germany
- Brina Malnar at the University of Ljubljana

The Centre for Comparative Social Surveys was set up in the School Social Sciences in October 2003 and works closely with the Department of Sociology. It hosts the multi-nation European Social Survey (ESS) funded by the European Commission, European Science Foundation and national funding agencies. The Centre is the lead partner in the project, under its director and Principal Investigator, Professor Roger Jowell, together with Rory Fitzgerald, Gillian Eva, Caroline Roberts and Mary Keane. The ESS is designed to measure and explain trends in attitudes, beliefs and values across countries in Europe (and its close neighbours). Designed to exceptionally high standards, its twin aims are to improve comparative social measurement within and beyond Europe. Fieldwork is conducted every two years.

In every round, core questions are asked about political orientations, attitudes and behaviour; underlying social and moral values; national, ethnic and religious allegiances; and, socio-demographic variables. Other topics are covered on a ‘rotating’ basis, following a Europe-wide competition. So far subjects such as immigration and asylum, active citizenship, attitudes to health and medicine, the balance between work and family and economic morality have been, or are about to be fielded.

The themes covered in the core modules are:

Trust in institutions
Political engagement
Socio-political values
Moral and social values
Social capital
Social exclusion
National, ethnic, religious identity
Well-being, health and security
Demographic composition
Education and occupation
Financial circumstances
Household circumstances
ESS data are freely available to anyone and may be accessed directly via the archive at http://ess.nsd.uib.no or through the ESS main website www.europeansocialsurvey.org

New Policy Institute Published by Joseph Rowntree
Monitoring poverty and social exclusion 2006
Guy Palmer, Tom MacInnes and Peter Kenway

This survey has been undertaken since 1998 and divides into the 3 age related areas. EU indicators are also available on the web-site www.poverty.org.uk

The indicators that they use are listed below.

**Low Income**

**Trends in low income**
1 Numbers in low income
2 The impact of housing costs
3 Low income by age group
4 Income inequalities
5 Lacking essential items

**In receipt of state benefits**
6 Out-of-work benefit levels
7 Long-term working-age recipients of out-of-work benefits

**Children**

**Economic circumstances**
8 In low income households
9 In receipt of tax credits
10 In workless households

**Health and well-being**
11 Low birthweight babies
12 Child health
13 Underage pregnancies

**Education**
14 Low attainment at school (11-year-olds)
15 Low attainment at school (16-year-olds)
16 School exclusions

**Young adults**

**Transitions to adulthood**
17 Without a basic qualification
18 School leavers
19 With a criminal record

**Economic circumstances**
20 Unemployment
Health and well-being

21 Low pay

22 Suicides

Working-age adults

Economic circumstances

23 Low income and work
24 Low income and disability
25 Low income and council tax
26 Concentrations of low income

Exclusion from work

27 Wanting paid work
28 Work and disadvantaged groups
29 Workless households

Low pay

30 Low pay by gender
31 Low pay by industry
32 Pay inequalities

Disadvantaged at work

33 Insecure at work
34 Support at work

Health and well-being

35 Premature death
36 Limiting long-standing illness
37 Mental health

Older people

Economic circumstances

38 In low income households
39 Non-take-up of benefits

Health and well-being

40 Excess winter deaths
41 Limiting long-standing illness

Isolation and support

42 Help to live at home
43 Anxiety

Community

Access to services

44 Without a bank account
45 Without home contents insurance
46 Transport

Housing

47 Polarisation by tenure
48 Without central heating
49 Homelessness
50 In mortgage arrears

www.poverty.org.uk
In their turn, the indicators in these reports are themselves only a small subset of the complete set of indicators which have been created as part of this project, all of which are available on the project website, www.poverty.org.uk. At the last count, the website contained more than 750 graphs and around 50 maps, drawing on a combined databank some 40Gb in size.

Anybody interested in any of the material in this report should, if they wish to explore further, visit the website. Anybody wishing to reproduce material from the report is also encouraged to visit the website to check that there is not more up-to-date information or later version of a graph. While the reports come out annually, the graphs on the website are updated within a few weeks of the data being published. The data behind every graph is also available on the website. Use of this material is acknowledged: ‘www.poverty.org.uk, published by the New Policy Institute on behalf of the Joseph Rowntree Foundation’.
Appendix 4
Concept Maps
MAP 3: Social Work Students (1st Year)

Definition of Exclusion
- Excluded
- Isolated
- Judged
- Don't Fit
- Anywhere
- Stereotyped
- Stereotypes
- Choice

Definition of Inclusion
- Not Excluded people
- Not being excluded because of gender, race, etc.
- Socialized
- Choice
- Accepted in society

Rights and Responsibilities of Inclusion
- Choice
- Overcoming barriers that prevent people from having an active social life
- Rights of the individual to respect their choice without exclusion

Objectives of Inclusion
- Included in social activities with friends
- Enabling people to take part in local groups/activities of their choice
- Rights to services
- Human rights

Models of Exclusion
- Inclusion of people with mental health problems
- Inclusion of people with learning disabilities

Social Policy
- Being socially accepted
- Being included in society
- Being part of a group
- Being included in the community
- Socially represented
- Rights to services
- Equal opportunities

UN Human Rights
- Group work
- Equal opportunities
- Fulfilled physically and emotionally

Human rights
- Rights to services
- Rights to everyday rights
- Equal opportunities
- Included in social activities with friends
- Human rights

Children
- Young people
- Young careers
- Young careers
- Young people

MAP 3: Social Work Students (1st Year)
MAP 4: Members of the Mental Health and Employment Working Group. A multi-disciplinary group of professionals
MAP 5: Women’s Forum

Social Inclusion

Identity
Community
Confidence
Positive Past Experiences

Social Exclusion

Isolation
Fear
Negative Past Experiences

State; Inability to Self Help; Service
Provision
Well Being
Finance
Ignorance
Conflict
Employment
Foundation/Root
Education
Social Exclusion

Social Inclusion

Food
Built environment
Housing
Surroundings
Language

• Advocacy
• Awareness
• Opportunity
• Knowledge of system in a society
• Accessibility
• Eligibility Criteria and Targeted Services

Discrimination Not Celebrating the Difference

• Immigration
• Age
• Race & racism
• Disability
• War/ asylum
• Class
• Culture barriers
• Different religions
• People’s behaviour

Ignorance

• Stereotyping
• Stigmatised
• Assumptions

Lack of understanding

• Work experience
• Skills and abilities

Employment

Health & disabilities

Substance misuse

Well Being

Mental depression

Facilities

• Motivation
• Requirement & interest
• Hierarchy of oppression

Social Exclusion

• Crime
• Intimidation
• Family breakdown

• Abuse
• Bad treatment
• Gang war

• Domestic violence

• Finance

• Debt
• Benefits
• Poverty

• Substance misuse
• Health & disabilities

• Social exclusion

• Labeling
• Labelling
• Assumptions
• Stereotyping

Lack of understanding

• People’s behaviour
• Culture barriers
• Different religions

• Age
• Race & racism

• Disability
• War/ asylum

• Immigration

State; Inability to Self Help; Service
Provision

Transport and mobility
Human rights

• Motivation
• Requirement & interest
• Hierarchy of oppression

• Facilities

• Motivation
• Requirement & interest
• Hierarchy of oppression

• Facilities

• Motivation
• Requirement & interest
• Hierarchy of oppression

• Facilities

• Motivation
• Requirement & interest
• Hierarchy of oppression

• Facilities

• Motivation
• Requirement & interest
• Hierarchy of oppression

• Facilities

• Motivation
• Requirement & interest
• Hierarchy of oppression

• Facilities

• Motivation
• Requirement & interest
• Hierarchy of oppression

• Facilities

• Motivation
• Requirement & interest
• Hierarchy of oppression

• Facilities

• Motivation
• Requirement & interest
• Hierarchy of oppression

• Facilities
MAP 6:
Staff of a Black and Minority Ethnic Cultural Association and an Age Concern

The Evolution of Communities: The Continuous Struggle for Social Inclusion

Stage 1: Struggle for Inclusion / Disadvantaged
- Separation and Isolation
- Not for Black and Ethnic Minority groups but for Main ? Groups
- Negativity e.g. Islam phobia and Ageism
- Lack of Opportunity and Poverty
- Stigma
- Language Barrier e.g. Refugees
- Isolation

Stage 2: Recognising Individual and Community Contribution
- Engaging the community
- Volunteering
- Being respected
- Involvement in Neighbourhood e.g. knowing and being known by neighbours in your street
- Choice
- Being recognised and Valued e.g. Role of unpaid career
- Respect

Stage 3: Tracking inequalities and barriers
- Fear of Crime
- Health
- Housing
- Employment
- Disability
- Area that you live in: unemployment and deprivation
- Casual Work: Class, unemployment and working groups
- Having means to socialising: transport, money & friends
- Education e.g. community, school
- Economic inclusion first
- Money

Stage 4: Influencing Change
- Lack of political clout or muscle
- Government propaganda
- Influencing change
- Responsibility
- Advocacy and support
- Having a voice in how I live and choose to live independently
- Addressing the social injustice superficially
- Organisational discrimination
- Representation
- Power
- Control

Stage 5: Celebration of differences and Continuation of Struggle
- Age
- Integration
- Equality
- Religious Tolerance and Ignorance
- Celebrating Diversity
- Learning e.g. of the similarities within the differences
- Evolution of Communities
- Race and cultural differences
- Understanding
- Provision
- Appropriate Facilities

The Evolution of Communities:
Stage 1: Struggle for Inclusion / Disadvantaged
Stage 2: Recognising Individual and Community Contribution
Stage 3: Tracking inequalities and barriers
Stage 4: Influencing Change
Stage 5: Celebration of differences and Continuation of Struggle
MAP 7: Attendants of a Drop-In Centre for people over 55.

INTEGRATION
- Class barriers
- Inclusion in the community
- Seem to think that the English should change
- Integration of all society in all aspects of life
- Some people are some religions are more inclusive than others
- Traditional festivities e.g. Christmas are expected to be cancelled out—need to strike a balance

INCLUSION BY SERVICES
- Immigration
- Language barriers
- Class barriers
- Inclusion in the community
- Participating
- Made to feel at home
- Welcoming

GENERATION GAP
- Respect
- Old and young people together
- Only older tenants attend tenants association meetings
- People need to want to be included
- Different cultures e.g. Italians are more family minded
- Offensive and upsetting behaviour
- Excluding oneself
- Generation gap

FAMILY LIFE AT A DIFFERENT TIME AND SOCIETY
- Trust
- Don’t want to be a burden on family
- Children move away from home to pursue economic opportunities elsewhere i.e. employment
- The high cost of childcare means more women are out in the workplace. No one remains at home
- The UK has the least breaks and holidays in Europe
- People are trying to progress all the time
- All other family members just too busy working
- Residential homes are a result of less family support
- Housing—cost of homes in different neighbourhoods—people move away
- Live in a different time and society
- People just don’t have the time
- Independence
- Money

INCLUSION BY SERVICES
- Voluntary Service e.g. Age concern
- Services for people with disabilities
- Education services
- Transport
- Health services
- Other public services
- More funding made available to include all
- Neighbourhood
- Welcoming
- Made to feel at home
- Participating
- Belonging
- Trust
- Old and young people together
- Only older tenants attend tenants association meetings
- People need to want to be included
- Different cultures e.g. Italians are more family minded
- Offensive and upsetting behaviour
- Excluding oneself
- Generation gap
- Respect
Choosing Inclusion
- Maintaining culture maybe construed as choosing to remain excluded
- Choice
- Need to adapt to a certain extent
- Need to make an effort to integrate
- Stopping groups from separating themselves from majority
- Individual ethnic groups excluding themselves from other groups in society

Teenagers
- Foster care
- Bullying
- Including teenagers through the arts
- Children and teenagers
- Teenagers don’t differentiate between the real world and what is portrayed in the media
- ASBOs as a badge of honour in recent times
- Exclusion in schools

Arts
- Learning new things
- Sports
- Music
- Crossing class boundaries

Social Inclusion
Factors Influencing Chances of being Included or Excluded.
The Factors of Life

Emotions
- Violence
- Aggression
- Fear
- Threat
- Abuse

Local neighbourhood / social environment and community
- Caring
- Support networks
- Birth and postcode lotteries
- No one cares - living in a materialistic society
- Gated community
- Learn from other countries South Africa (discrimination), Jamaica (crime) etc.
- Selfish society
- Neighbourhoods
- Product of environment: don’t be a sheep
- Opportunities: same chance to all social groups
- Included in smaller groups and excluded in wider society

Disabilities
- Mental illness
- Care in the Community
- Hard to reach groups
- Stereotyping of black men and mental health

Family
- Young and old getting along
- Learnt behaviour
- Role models
- Respect
- British teenagers worst in Europe
- Relationships with other people

Media and politics
- Exclusion perpetuated and encouraged by media
- Politicians
- Media: Hidden agenda
- Having a voice
- Social and economic climate of the time
- Perceptions

Outcasts / Differences / Discrimination
- Acceptance
- Integration within society
- Separate but included???
- Doing things with other ethnicities
- Tolerance
- Acceptance of different races, cultures and beliefs
- Trying to make all social groups feel part of larger society
- Language barriers
- Change with every generation: Attack and defence
- Understand and accept others’ beliefs
- Are Muslims as understanding as they expect us to be of their religion?
- Wearing religious head gear
- Creating a social environment that encourages the embracing of differences

Work
- Work
- Ability to work
- Equal opportunities

MAP 8: General Population