

Social Inclusion as Freedom for Persons Living with Mental Illness

Phyllis Montgomery
Laurentian University

Amy Wuest
Western University

Cheryl Forchuk
Lawson Health Research Institute

Tracy Smith-Carrier
Western University

Momodou S. Jeng (Mo)
City of London

Abraham (Rami) Rudnick
Thunder Bay Regional Health Research Institute

ABSTRACT

This study describes the meaning of social inclusion to persons living with mental illness and poverty. Participants were recruited from health and social services where they completed the Community Integration Questionnaire (CIQ). From this sample, 46 participants attended one of three focus groups that corresponded with their self-reported CIQ scores. Thematic analysis showed that regardless of their CIQ

Phyllis Montgomery, School of Nursing, Laurentian University, Sudbury, Ontario; Amy Wuest, Rothman Institute of Philosophy, Faculty of Arts and Humanities, Western University, London, Ontario; Cheryl Forchuk, Beryl and Richard Ivey Research Chair in Aging, Mental Health, Rehabilitation and Recovery, Lawson Health Research Institute, London, Ontario; Tracy Smith-Carrier, School of Social Work, King's University College, Western University, London, Ontario; Momodou S. Jeng, Policy and Planning Manager, City of London, London, Ontario; Abraham (Rami) Rudnick, Thunder Bay Regional Health Sciences Centre, Thunder Bay, Ontario.

Abraham (Rami) Rudnick is now at Department of Psychiatry, School of Occupational Therapy, Dalhousie University, Nova Scotia. Amy Wuest is now at Bingham Internal Medicine Residency—Idaho Physicians Clinic.

This research was funded by the Social Science and Humanities Research Council (Community University Research Alliance Award). The authors report no related conflicts of interest.

Correspondence concerning this article should be addressed to Phyllis Montgomery, School of Nursing, Laurentian University, Ramsey Lake Road, Sudbury, ON, P3E 2C6. Email: pmontgomery@laurentian.ca

scores, participants described freedom as both a liberating process for, and outcome of, social inclusion; freedom allows for the accumulation of health and social capital commensurate with one's complex needs, and freedom represents success in the construction life surrounded by affirming others.

Keywords: community integration, freedom, mental health, social inclusion

RÉSUMÉ

La présente étude ethnographique avait pour objet de décrire le sens de l'inclusion sociale du point de vue de personnes pauvres et atteintes d'une maladie mentale. Ces dernières provenaient de divers programmes de santé et de services sociaux. Après avoir rempli le questionnaire d'intégration communautaire (CIQ), 46 participants ont assisté à l'un des trois groupes ciblés de discussion correspondant à la note qu'ils déclaraient avoir obtenue au CIQ. L'analyse thématique a révélé que peu importe leur note au CIQ, les participants ont décrit la liberté comme étant à la fois un processus libérateur d'inclusion sociale et le résultat de cette même inclusion. La liberté permet d'accumuler un capital santé et un capital social à la hauteur de ses besoins complexes. La liberté représente le fait de réussir à se bâtir une vie significative, entouré de personnes qui jettent sur soi un regard positif.

Mots clés : intégration communautaire, liberté, santé mentale, inclusion sociale

Persons with mental health issues are among the most marginalized groups in society (Cobigo & Stuart, 2010; Morgan et al., 2007). From their perspective, the label “mental illness” prompts exclusionary practices, despite their efforts and desire for belonging (Mental Health Commission of Canada, 2010). Killapsy et al. (2014) investigated changes in social inclusion and exclusion before and after a mental illness diagnosis. They found a statistically significant reduction in two aspects of social inclusion, social integration, and productivity, following the onset of the illness. Although illness negatively impacts social inclusion, it had a greater negative impact on integration and productivity for individuals who were previously engaged in their environments. Lloyd and Moreau (2011) found that individuals diagnosed with mood and anxiety disorders sought social inclusion by attempting to blend in seamlessly among others in society, i.e., to have a “normal” life.

Managed illness symptoms can mask disparaging life circumstances and associated changes in one's roles, functions, and status, which entrenches social “dis-memberment” (Lloyd & Moreau, 2011; Millier et al., 2014). In recent decades, while there has been a shift towards community integration for individuals with managed illness, there is recognition that multiple, intersecting issues inhibit the process of social inclusion. Particular to individuals with mental illness, these include chronicity, poverty, insecure housing, stigma, discrimination, and limited access to appropriate services (Arboleda-Florez & Stuart, 2012; Capponi, 1997; Forchuk, Ward-Griffin, & Csiernik, & Turner, 2011; Livingston & Boyd, 2010). As such, in developed countries social inclusion is viewed as an essential component of emerging mental health policy. For example, the Mental Health Commission of Canada (2010) characterized eight attributes of social inclusion bound by interpersonal processes for optimizing individuals' functioning.

In a recent review of the evidence concerning the social inclusion of people experiencing mental illness, Wright and Stickley (2013) identify a disconnect between policy and practice. They partly attribute

this disconnect to the lack of conceptual overlap between social inclusion and social exclusion. As a result, healthcare providers' and decision makers' efforts to promote persons' rights, support their choice for meaningful contributions to society, and reduce health inequalities may be impeded. Clifton et al. (2013), however, argue that actualizing social inclusion in mental healthcare contexts requires coordinating isolated efforts to promote agency through substantive changes in social, economic, political, and cultural structures. Becoming socially included is most likely when the service structure adapts to individualized needs as opposed to the other way around (Wright & Stickley, 2013).

A social inclusion agenda in Australia prioritized supports, networking, and the participation of all community members with a particular emphasis on those living with multiple and complex disadvantages (Australian Social Inclusion Board, 2012). Being single, ill, unemployed, and having lower levels of education was associated with impaired social functioning for nearly two-thirds of a national cohort of Australian adults with psychosis (Stain et al., 2012). These researchers reported that the most challenging issue for those surveyed was loneliness and social isolation (37%). In addition, nearly 50% of the cohort wanted more friends, 34% wanted support to secure new relationships, and 61% wanted to eliminate stigma and discrimination. Further, they suggested that the advancement of social inclusion for persons with psychosis requires stakeholders from multiple health and social sectors to actively collaborate to ensure the availability of opportunities for all. Similarly, Hamer, Finlayson, and Warren (2014) proposed that social inclusion necessitates community-wide investments and actions beyond the biomedical model for active citizenship.

Innovative community development initiatives provide alternative ways to increase the community participation of persons with mental illness (Belle-Isle, Benoit, & Pauly, 2014; Mandiberg, 2012). Although variable, these initiatives share principles such as capacity building, realignment of power, effective partnerships and coalitions, social capital, social justice, and equality at community and policy levels (Kirsh, Krupa, Cockburn, & Gewurtz, 2010; Labonte, 2004). In North America and the United Kingdom, entrepreneurial enterprises for persons with mental illness are primarily social and are not aimed at "profit maximization" (Buhariwala, Wilton, & Evans, 2015). These researchers found that flexibility, security, and support within and outside of work promoted social inclusion as well as business success. The potential of social enterprise activities to achieve their mission of encouraging social inclusion through person-centred well-being initiatives is an area requiring further study (Roy, Donaldson, Baker, & Kerr, 2014).

Fostering social inclusion is a fundamental part of ensuring that persons living with mental illness are able to live fuller lives. Given the problematic constellation of inequalities faced by this segment of our society, such as discrimination and poverty, additional research is needed to advance clinicians' and program planners' understanding of the individualized and variable nature of social inclusion amongst persons with mental illness (Belle-Isle et al., 2014; Clifton et al., 2013). In light of this gap, a five-year, mixed-method study was conducted to explore how poverty affects the social inclusion of people living with mental illness in London Ontario (Doherty, Wright, Forchuk, & Edwards, 2014). In this qualitative paper, the authors describe the meaning of social inclusion from the perspectives of persons living with mental illness.

METHOD

Design

In the five-year primary study, an ethnography design was used to gain insights from a group of individuals about their daily lives and how their environments inform those experiences (Richards & Morse, 2013; Robinson, 2013). This method focuses on understanding individuals' lives in their own words to generate meaning by studying human behaviour, emotion, and belief patterns. For the purpose of this paper, however, qualitative descriptive, as compared to ethnographic, methods were used as only one data set, collected in the second year of the study, was used to reveal participants' experiences, perceptions, and beliefs of social inclusion. Research ethics approval was obtained from the Research Ethics Board of Western University, London.

Participants

Community-dwelling persons living with mental illness do not constitute a homogeneous population. Contributing to this group's heterogeneity in this study's setting of southwestern Ontario, is varied illness trajectories, health and social inequalities, cultural backgrounds, and gender issues, to name but a few. In the second year of the primary study, using various sampling methods, 400 people, 18 years of age or older with self-identified mental illness were recruited through known locations of congregation including shelters, drop-in centres, and meal programs. All participants were proficient in English. Overall, data from the second year ($n = 400$) had an equal number of males and females (50%). Nearly 70% reported a history of homelessness, and the mean age of their initial experience of homelessness was 23.48 ($SD \pm 11.4$). Participants estimated that the mean amount of money that they spent on themselves after paying for accommodation and food was \$226.47 ($SD \pm 443.14$) per month.

Data Collection

In each year of the primary study, participants were invited to complete a structured quantitative interview. An instrument within the quantitative interview was the 15-item CIQ. It measures the extent of community integration across three domains: their lives at home, their social lives, and their level of productivity (Willer, Ottenbacher, & Coad, 1994). In addition, at the end of quantitative data collection, participants were asked to indicate if they wanted to take part in a focus group that would address their experiences of social inclusion. The total CIQ scores, ranging from 0 to 29, were used to create separate semi-structured focus groups that reflected participants' levels of community integration: low (0–9), medium (10–19), and high (20–29) CIQ groups. Participants who expressed a willingness to participate in a focus group were invited to attend with other participants who had similar CIQ scores.

A total of 46 persons attended one of seven focus groups: two low CIQ groups ($n = 12$); two medium CIQ groups ($n = 12$); and three high CIQ groups ($n = 22$). The topics of discussion during each semi-structured focus group were: (a) experiences and perceptions of social inclusion; (b) factors that promote or hinder social inclusion; and (c) their recommendations to improve social inclusion. During each audio-recorded focus group, an experienced facilitator guided the discussion, ensuring that every participant had the opportunity

to share their experiences. Two trained research assistants recorded field notes descriptive of group members' nuances, subtle expressions, and behaviours. No sociodemographic information was systematically collected from focus group participants, which meant it was not possible to match qualitative and quantitative data. All participants received a \$20 honorarium.

Data Analysis

All focus group data were transcribed verbatim. The field notes, enclosed in square brackets, were inserted into the transcripts. A third research assistant checked the transcribed interviews for quality and consistency by reading each transcript while simultaneously listening to the corresponding audio recording. Any discrepancies were corrected on the transcripts prior to analysis. A thematic analysis was used to identify, examine, summarize, and reconstruct the patterns of meaning within each of the CIQ data sets (Braun & Clarke, 2006; Richards & Morse, 2013; Willig, 2014). The format of the printed transcripts allowed researchers to independently read the text line-by-line, highlight sections of text, and to identify preliminary, descriptive code labels in the margins. Then, they met as a team to discuss their initial codes for each of the three CIQ groups. With a shared understanding of the descriptive features of the codes, the data were reduced (Richards & Morse, 2013). Then, guided by the evolving interpretations of each group of codes, a smaller working group examined the relationships between the coded data to generate higher-level theoretical labels. The core question guiding the analysis was: what is the essence of social inclusion within the categorized data? The thematic responses to this question were reduced into a matrix format and shared with the whole team for further interpretation.

RESULTS

Within the focus groups, designated by CIQ scores, 20 men and 26 women described variable experiences of social inclusion. A common feature across the groups was the importance of expending effort towards the accumulation of health and social capital to live a meaningful life. Activities to this end were supported through affinity with trusted friends, family, and service providers. Positive advancements towards a meaningful life were indicative of their growing freedom. With visible progress towards their goals, participants talked about their developing self-esteem, connecting with affirming others, accessing safe places, and attaining belonging. Participants valued intentional involvement in designing their life and regard by others. One participant explained,

I started tearing down the walls that I had built up ... I started getting help and I started trusting people. And, yes, there been times when I've been knocked down, but you know what? ... 95% of the time the people that you meet are really good people. ... My self-esteem grows incrementally because of that ... I just feel better about myself and because of that people like me better.

Among supportive and affirming others, it was feasible for participants to make choices, accept the implications of their choices, and to be authentically present. To "help me help myself" was perceived by participants as "the biggest tool that anybody can give us." Such circumstances reinforced participants' drive to thrive as opposed to "just survive." The flexibility to actively establish and sustain meaningful connections was integral to participants' "peace and mental welfare." In describing preferred modes of being

involved, participants stated that they wanted the freedom to be “just one person amongst a bunch of other people in society.”

In contrast, when opportunity to orchestrate their lives was restricted, participants indicated that their integrity was at risk. Constellations of health, social, nutritional, and housing disadvantages constricted the freedom to nurture growth-producing connections. Many of their efforts were spent in forming need-based bonds for the immediate security of health, food, and housing. If unable to address their immediate needs, they experienced a “magnification of problems,” contributing to “much more isolation,” and an ultimate threat to their freedom. A participant stated,

...there is no freedom. I don't feel like I could look at somebody and say, “I'm having a really crappy day.” When I say “I'm fine,” it really means “I'm freaked out, I'm insecure, I'm neurotic and emotional” ... I just have to put on that phony smile and say, “oh, uh, I'm fine.” I'm probably not fine.

When authentic self-disclosure is compromised in the presence of non-supportive and untrustworthy individuals, freedom was perceived as limited or at times absent. Overall, participants, described freedom as a liberating process in which one's genuine needs are identified and addressed. Further, freedom was an outcome of successfully building of one's meaningful life despite entrenchment in challenging health, social, and financial contexts.

High CIQ Group Participants

For those with high CIQ scores, social inclusion was characterized as belonging to social networks that recognized and valued their individuality regardless of their limited access to material resources. In this group, participants' social bonds extended beyond service providers. They were actively involved in various communities of supportive, protective, and guiding companions with similar interests. Their social networks include validating, protective, and guiding alliances with family and friends who may or may not have been associated with communities made up of other psychiatric survivors. Participants described “good people” in their lives as those that “gave me the opportunity to prove myself ... so it made me feel better about myself.”

Achieving inclusivity within a social network was by no means haphazard for participants. Rather, they strategically exercised their freedom to be “picky and choosy in who I hang around with.” With time and wellness, they devoted energy to create and sustain trustworthy, affirming and “enjoyable” bonds with others. One participant elaborated,

I guess it is not coincidental in the least that the people that I am closest with are also on disability ... we have opened up ... gradually over time, and understand each other, the obstacles of moving ahead, and overcoming it [mental illness].

“Being selective” offered participants the freedom to be authentically present. They were less reliant on silencing their voices or masking their symptoms when among like others. With genuine inclusivity, the “luxury of self-acceptance” offered the possibilities of achieving goals such as “becoming stronger,” “staying connected,” “increasing my stability,” and “being more in control of my life.” In turn, success fuelled a forward momentum. “Moving forward” despite financial poverty was more likely when participants experienced “safe-spaces” of their own design. Safety facilitated mindfulness of the potential risks associated with particular health and social options, and a willingness to accept accountability for their decisions.

Medium CIQ Group Participants

For individuals in this group, their freedom to self-actualize was framed by sustaining positive, day-to-day functioning in collaboration with service providers. Persons willingly engaged with providers who communicated a therapeutic presence: “working with me, helping me, and walking alongside me.” This type of partnership facilitated freedom through understanding and mapping their current health and social needs towards a desired life. For example, a participant described decision-making power as a care partner in response to a worker’s invitation: “these are the choices that you need to make. It is up to you to make them and if you wish to discuss it, we will discuss it in a year or two years from now.” Within the “hugely supportive” partnerships with providers, participants were more likely to venture into the community for the purpose of “trying some things” towards their life goals.

Unfortunately, being free to work with a concerned, “non-controlling” provider was not universal for all participants in the medium CIQ group. Some participants considered themselves “lucky” to get “so much support over the years.” Luck, as described, facilitated health and social “stability,” inclusive of an accumulated network of friendly providers across a range of sectors. Participants valued the ability to “go to any one of the staff” who willingly “talk[s] with me and tr[ies] to help me.” By accruing intra- and inter-sector supports, participants established a network of providers who were perceived as accepting of them.

Financial struggles generated pervasive mental stress, “constant, constant, constant worrying about money.” Their preoccupation with addressing their immediate needs restricted free choice. In poverty, participants described the injustices of being “push[ed] to do things that normal people didn’t do, like the things that people with moral values, like, they wouldn’t do them.” Participants with limited freedom were unable to actualize valued life goals. For example, participants were denied their right to be parents:

I had a mental episode but I was told by the lawyer, ‘If you claim you were having a mental episode they’re going to lock you away for two years or more.’ ... My lawyer feared me into not going this route [disclosing my mental illness] ... I’m entitled to one hour [of visitation] every two weeks... It is just a big heartbreak. I don’t like really mentioning it ’cause who wants to be a dead-beat parent, but that is not my choice [participant began crying].

Within the medium CIQ group, limited resources restricted their freedom and often were noted to “separate you from people in your life.”

Low CIQ Group Participants

A precursor to freedom was a “safe environment where I know I’ll be respected, and not ridiculed.” Freedom was elusive in the absence of trustworthy others to assist them to move beyond despair and objectification. Often participants in this group experienced being “treated like a number and a pile of paper work rather than a human being.” They described the importance of “fit[ting] into one of the boxes” to access basic resources or risk “a lot of social exclusion.” To promote the appearance of fitting in, participants acknowledged the need to “work really, really hard to be ... on your best behaviour.” Otherwise, as lived by a participant, marginalization was pervasive:

... the stereotypes that exists, right? And if you fit a certain number of the criteria for [those] stereotypes you are automatically ... put there [e.g., stereotyped] and that is how you are treated. I have faced this

in hospitals. If you are stereotyped as a drug user then you are instantly treated like crap. ... If you are dealing with police and legal situations, if you are put in the lower economic class then you are generally treated like crap.

Low CIQ participants sought opportunities to expand their freedom beyond the “survival” to the “living level.” With multiple unmet needs, some individuals perceived that “this system was not set up [for] someone like me.” For one participant, “it is almost as if the government is intentionally setting you up to fail, just to see who rises above. And honestly, it’s just a game.” But, playing the game did not enhance their freedom either, since the available options were often not suitable or appropriate for their needs. The illusion of choice increased their distress in relation to making “good choices” or prioritizing their immediate needs. As one participant stated, “I need my mental health meds, before I need food.” Financial restrictions intensified the illusion of choice. “I am putting out way more money at the cash register and bringing home way less food.” Given the pervasive experience of disadvantage, very few choices were perceived as fair because participants knew that they had to sacrifice some needs in order to meet other basic needs.

Participants in this group wanted “to be accepted as we are with our foibles.” Their efforts for freedom, however, were often thwarted. The presence of illness and indicators of exclusion (poverty, unemployment, homelessness, residing in unsafe neighborhoods) limited their freedom to

... have good relationships with people because they don’t understand ... I have actually found people resentful of me ... feeling that I’m always backing down. I can have the greatest intention ... make all the plans that I want, but if I’m sick, if I’m tired, I just, I can’t do it. And sometimes I just can’t push past it. So it has affected me in relationships ... with [getting] jobs.

A typical strategy to establish inclusion was wearing a “mask,” to conceal their authentic life circumstances. That is, “to have two different personas, the persona that I want people to see and the real-self.” In doing so, freedom as an outcome was compromised.

Across the three CIQ groups

Regardless of their CIQ group, most participants identified experiences of discrimination and stigma. As the CIQ scores decreased, marginalized experiences became increasingly pervasive. Many participants emphasized that they did not “choose” to be mentally ill or poor. Their current circumstances, however, necessitated engagement in a life plan that they did not envision prior to the onset of the illness. Social disadvantage limited their freedom to adapt and to “have a sense of pride,” which is a precursor to forming meaningful bonds outside of their immediate surroundings. For example, participants shared experiences of discrimination in the context of formal employment. As illustrated by one participant:

If I tell a potential employer right away that I have a mental illness, he could ... use that to discriminate and say, “Well, I don’t want to take a chance on someone that has a mental illness,” and just not call me after I handed in my résumé.

Participants, regardless of their CIQ group, valued “anti-discrimination laws,” and classified those laws as “good rules.” Enactment of such laws held the promise to experience freedoms afforded to others without difference:

It is definitely a form of discrimination that needs to be addressed ... because they sit in silence especially if they are not able to work to some degree and have social interactions. This only magnifies problems as they become much more isolated. ... I'm reluctant to bring it up all by myself ... I don't want to be identified ... again because of the stigma.

In the high CIQ group, participants wanted to be free from being primarily identified by their experiences of mental illness. Mindful of their goals, access to resources, and the reliable presence of others mitigated but did not eliminate their past experiences of exclusion. Further, they continually feared potential experiences of others "call[ing] me psycho or something."

Similarly, members of the medium CIQ group shared their experiences of exclusionary practices in relation to gender, employment, service use, and public housing issues. For example, the criminal justice system was perceived as discriminatory due to providers' lack of education about mental illness. As a result, their "civil liberties" and hope for a different life were impeded. Likewise, for those receiving assistance from the Ontario Disability Support Program, they described the continuous pressure to "prove yourself innocent" to sustain eligibility. In addition, they fell prey to ridicule on public transportation. "Buses are for poor people to get around the city." Relative to the location of their bus stop, particular neighborhoods were associated with being "automatically" judged as having no value.

For those in the low CIQ group, they shared stories of being addressed as "stupid," "dangerous," "irresponsible," "undesirables," and "involved with drugs and criminal activities." Being "accused" resulted in an internalized struggle:

I found I was stigmatizing myself and I perceived myself the way other people perceive mental health people... But, I'm not my diagnosis.

This prompted them to become increasingly suspicious about others' intentions. They were especially vigilant as they believed that others "lied to them," or that they were "spoken to like a child." Vigilance, although exhausting, was necessary given "the certain rules and hidden hoops you have to jump through in order to get proper care."

Being "formed" or undergoing involuntary inpatient mental health treatment was the ultimate example of the denial of freedom. As shared by two different participants:

When I was formed [certificate of involuntary admission] ... I had to take meds [and] I didn't even know what I was taking and they didn't tell me anything.

Why do you have to drug me up until I am comatose? And then life is hitting, hitting, hitting and I can't cope. And, I almost had a nervous breakdown because the drugs were clogging everything up and it was like, are you kidding? You are causing more damage.

Participants emphasized the importance of knowing your "rights" to avoid "having medications forced on you" or "getting locked up." Securing accurate information about one's rights and freedoms offered the hope that future care would involve a meaningful integration of personal preferences.

DISCUSSION

For this study's sample of persons living with mental illness, social inclusion was characterized in terms of freedom. Freedom was depicted as a process and outcome of actively participating in self-defined opportunities for a dignified life. Freedom to exercise life choices both required and begot social inclusion. This symbiotic coupling allowed some participants to achieve their goals through connections in the context of economic and social concerns. In respectful and valued relationships, an individual's deliberate actions for social inclusion can be validated and sustained.

For those with high CIQ scores, their experiences of freedom encompassed diverse activities beyond involvement in formal services. Typically, their social connections included other individuals living with mental illness. Through involvement in a micro-community, individuals have the opportunity to develop a facility with important overt and covert social rules and norms (Hamer et al., 2014; Wong, Stanton, & Sands, 2014). Experiential knowledge and genuine presence may even result in liberating circumstances. Further, progressive social inclusion could lay the foundation to challenge structural, society-wide barriers by coordinated actions within and amongst micro-communities (Ammeraal et al., 2013). In view of a national strategy to foster recovery by promoting equitable access to appropriate inter-sector resources (Mental Health Commission of Canada, 2012), this study contributed insights into the value of social inclusion as a means to increase freedoms for fuller participation in and contribution to one's community.

Person-centred relationships with formal service providers allowed persons with medium CIQ scores to mobilize resources to enhance freedom. In another study, Farone (2016) found that providers play a critical role in facilitating persons' abilities to locate themselves within desired social positions. Through access, awareness, and increased knowledge, Risjord (2014) argues that positive freedom, the enactment of meaningful choices, becomes increasingly likely in the context of mutually respectful interactions. To promote medium CIQ participants' social inclusion beyond services requires additional assistance, such as improved health and trusted supports. However, not every member of this group experienced freedom. Some participants described being "unlucky," having interactions with "uncaring" professionals and no "real" choices. The nature of the professional relationship can either positively or negatively influence the extent and quality of experiences of freedom.

It is important for both mental health service users and providers to co-produce a vision of social inclusion that addresses individualized needs (Clifton et al., 2013). Stylianos and Kehyayan (2012) suggest an advocacy model based on promoting service users' own perspectives and fostering their autonomy through active collaboration with service providers. Further, Minkler (2012) discusses four aspects of the "conscious contrarians," a role originally developed by Mondros and Wilson in 1994 in relation to inclusive communities. The role involves a worldview characterized by justice; a rejection of the mainstream's definition of power based on merit; an understanding that facilitating societal change for the marginalized in the current system is particularly daunting; and finally, an awareness of the benefits of positive deviance. Based on this study's findings, this role description has merit for the promotion of social inclusion through freedom.

For participants who self-reported low CIQ scores, their freedom was highly restricted, as they lacked a sense of control over their environment. Freedom is not fully experienced without supports for life-sustaining resources. Similarly, Wharne and associates (2012) found that exercising freedom was extremely difficult with

loss of life structures such as recognition beyond illness, personal relationships, productivity, involvement in leisure, and timely access to appropriate services. A fundamental resource for achieving social inclusion, via connectedness or citizenship pathways, is social currency or competencies built on managing available resources (Wong et al., 2014).

A study limitation was that the qualitative sample was drawn from persons living in one mid-size city which has a higher emergency shelter use compared to other Ontario communities and growing demands on food banks (City of London, 2011). Another limitation is that the qualitative data was shared with the researchers rather than observed by them, thus possibly limiting in-depth understanding. This method is typical of research using focus groups, but future research could use observations to develop a rich ethnographic description.

This study sought to understand the meaning of social inclusion from the perspectives of community-residing persons who self-reported low to high CIQ scores. The frequent use of the term freedom, or variations thereof, was initially overlooked during data analysis. References to freedom were initially interpreted relative to basic legal rights. With further analysis freedom was understood as a defining attribute of social inclusion, regardless of CIQ scores. As the analysis of data sets within the five-year study progresses beyond the results presented in this paper, it would be of potential benefit to extract quantitative data specific to social inclusion, community integration, and freedom to advance understanding about the associations among and between these concepts.

REFERENCES

- Ammeraal, M., Kantartzis, S., Burger, M., Bogeas, T., van der Molen, C., & Vercruysse, L. (2013). ELSiTO: A collaborative European initiative to foster social inclusion with persons experiencing mental illness. *Occupational Therapy International*, 20(2), 65–74. doi:10.1002/oti.1342
- Arboleda-Florez, J., & Stuart, H. (2012). From sin to science: Fighting the stigmatization of mental illness. *Canadian Journal of Psychiatry*, 57(8), 457–63.
- Australian Social Inclusion Board. (2012). *Social Inclusion in Australia: How Australia is faring*. 2nd ed. Canberra (Australia). www.socialinclusion.gov.au
- Belle-Isle, L., Benoit, C., & Pauly, B. (2014). Addressing health inequities through social inclusion: The role of community organizations. *Action Research*, 12(2), 177–93. doi:10.1177/1476750314527324
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
- Buhariwala, P., Wilton, R., & Evans, J. (2015). Social enterprises as enabling workplaces for people with psychiatric disabilities. *Disability & Society*, 30(6), 865–79. doi:10.1080/09687599.2015.1057318
- Capponi, P. (1997). *Dispatches from the Poverty Line*. Toronto (ON): Penguin.
- City of London. (2011). Fact sheet: London's low income measures. <https://www.london.ca/About-London/community-statistics/social-issues/Documents/Low%20Income%20facts%20and%20figures.pdf>.
- Clifton, A., Reppe, J., Banks, D., & Remnant, J. (2013). Co-producing social inclusion: The structure/agency conundrum. *Journal of Psychiatric and Mental Health Nursing*, 20, 514–24. doi:10.1111/j.1365-2850.2012.01953.x
- Cobigo, V., & Stuart, H. (2010). Social inclusion and mental health. *Current Opinion in Psychiatry*, 23, 453–57. doi:10.1097/YCO.0b013e32833bb305
- Doherty, J., Wright, A., Forchuk, C., & Edwards, B. (2014). A Canadian community–university research alliance: Focus on poverty and social inclusion for psychiatric consumer–survivors. *World Medical & Health Policy*, 6(2), 150–57. doi:10.1002/wmh3.93
- Farone, D. W. (2006). Schizophrenia, community integration, and recovery: Implications for social work practice. *Social Work in Mental Health*, 4(4), 21–36. doi:10.1300/J200v04n04_02

- Forchuk, C., Ward-Griffin, C., Csiernik, R., & Turner, K. (2011). Surviving the tornado of mental illness: Psychiatric survivor experiences of getting, losing, and keeping housing. In C. Forchuk, R. Csiernik, & E. Jensen (Eds.), *Homelessness, housing, and mental health: Finding truths, creating change* (pp. 48–58). Toronto, Ontario: Canadian Scholars' Press.
- Hamer, H. P., Finlayson, M., & Warren, W. (2014). Insiders or outsiders? Mental health service users' journeys towards full citizenship. *International Journal of Mental Health Nursing*, 23, 203–11. doi:10.1111/inm.12046
- Killapsy, H., White, S., Lalvani, N., Berg, R., Thachil, A., Kallumpuram, S., Nasiruddin, O., ...Mezey, G. (2014). The impact of psychosis on social inclusion and associated factors. *International Journal of Social Psychiatry*, 60(2), 148–54. doi:10.1177/0020764012471918
- Kirsh, B., Krupa, T., Cockburn, L., & Gewurtz, R. (2010). A Canadian model of work integration for persons with mental illness. *Disability & Rehabilitation*, 32(22), 1833–1846. doi:10.3109/09638281003734391
- Labonte, R. (2004). Social inclusion/exclusion: Dancing the dialectic. *Health Promotion International*, 19(1), 115–21. doi:10.1093/heapro/dah112
- Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, 71(12), 2150–61. doi:10.1016/j.socscimed.2010.09.030
- Lloyd, S., & Moreau, N. (2011). Pursuit of a 'normal life': Mood, anxiety, and their disordering. *Medical Anthropology*, 30(6), 591–609. doi:10.1080/01459740.2011.596175
- Mandiberg, J. M. (2012). The failure of social inclusion: An alternative approach through community development. *Psychiatric Services*, 63(5), 458–60. doi:10.1176/appi.ps.201100367
- Mental Health Commission of Canada. (2010). *Roundtable #6: Social Inclusion and Mental Health - Highlights Report*. http://www.mentalhealthcommission.ca/English/system/files/private/FamilyCaregivers_2010RoundtableFrancoophoneMH_ENG_0.pdf
- Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada*. www.mentalhealthcommission.ca
- Millier, A., Schmidt, U., Angermeyer, M. C., Chauhan, D., Murthy, V., Toumi, M., & Cadi-Soussi, N. (2014). Humanistic burden in schizophrenia: A literature review. *Journal of Psychiatric Research*, 54, 85–93. doi:10.1016/j.jpsychires.2014.03.021
- Minkler, M. (2012). *Community organizing and community building for health and welfare* (3rd ed.). New Brunswick (NJ): Rutgers University Press.
- Morgan, C., Burns, T., Fitzpatrick, R., Pinfold, V., Brugha, T., & Jenkins, R. (2007). Social exclusion and mental health: Conceptual and methodological review. *British Journal of Psychiatry*, 191, 477–83. doi:10.1192/bjp.bp.106.034942
- Richards, L., & Morse, J. M. (2013). *Read me first for a user's guide to qualitative methods* (3rd ed.). Los Angeles, CA: SAGE.
- Risjord, M. (2014). Nursing and human freedom. *Nursing Philosophy*, 15, 35–45. doi:10.1111/nup.12026
- Robinson, S. G. (2013). The relevancy of ethnography to nursing research. *Nursing Science Quarterly*, 26(1), 14–9. doi:10.1177/0894318412466742
- Roy, M. J., Donaldson, C., Baker, R., & Kerr, S. (2014). The potential of social enterprise to enhance health and well-being: A model and systematic review. *Social Science & Medicine*, 123, 182–93. doi:10.1016/j.socscimed.2014.07.031
- Stain, H. J., Galletly, C. A., Clark, S., Wilson, J., Killen, E. A., Anthes, L., ...Harvey, C. (2012). Understanding the social costs of psychosis: The experience of adults affected by psychosis identified within the second Australian national survey of psychosis. *Australian & New Zealand Journal of Psychiatry*, 46(9), 897–89. doi:10.1177/0004867412449060
- Stylianou, S., & Kehyayan, V. (2012). Advocacy: Critical Component in a Comprehensive Mental Health System. *American Journal of Orthopsychiatry*, 82(1), 115–20. doi:10.1111/j.1939-0025.2011.01143.x
- Wharne, S. J., Langdrige, D., Motzkau, J., (2012). Decision-making in mental healthcare: A phenomenological investigation of service user perspectives. *The Humanistic Psychologist*, 40, 153–65. doi:10.1080/08873267.2012.669357
- Willer, B., Ottenbacher, K. J., & Coad, M. L. (1994). The community integration questionnaire: A comparative examination. *American Journal of Physical Medicine & Rehabilitation*, 73(2), 103–11.
- Willig, C. (2014). Interpretation and analysis. In U. Flick (Ed.), *The SAGE Handbook of qualitative data analysis* (pp. 136–149). Los Angeles, CA: SAGE.

- Wong, Y. L. I., Stanton, M. C., & Sands, R. G. (2014). Rethinking social inclusion: Experiences of persons in recovery from mental illness. *American Journal of Orthopsychiatry*, 84(6), 685–95. doi:10.1037/ort0000034
- Wright, N., & Stickley, T. (2013). Concepts of social inclusion, exclusion and mental health: A review of the international literature. *Journal of Psychiatric & Mental Health Nursing*, 20(1), 71–81. doi:10.1111/j.1365-2850.2012.01889.x