Measuring and using Social Inclusion- Building a nexus of facts, practices and knowledge through the lessons and capacities of public health

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"Social inclusion" has a following. The term is used to describe a range of social, legal, and economic policy objectives worth pursuing through their common purpose of realizing a vision of society as broadly participatory, enabling, engaged, …. inclusive. It remains to be seen, however, whether what is an often varyingly used concept depending on the context, purpose, or author, can become more than an organizing theme, and instead become a primary feature of governance.

Briefly, more rigorous definition and measures based in hypothesis-driven explanatory models will be needed to further move "social inclusion" from a placeholder for a cluster of qualities and characteristics of a liberal, civil, society, to a well understood mechanism of how social development works—"Social Inclusion." Efforts to render social inclusion as a more effective construct for policy should engage work in public health and mental health in at least 2 respects: 1) these fields can offer examples for generating similar complex social models and, 2) inclusive purposes are uniquely captured by these fields in terms of particular measures, interventions and services, uses of research, and possibilities for governance. But first, why do I start with a note of caution about Social Inclusion?

The challenges of a social "fact"

Just as it has a following, social inclusion also has a history in the sense that it can be seen within a larger story that previews some of its challenges. Highlighting inclusion, or participation, as a key casualty of social and economic deprivation, as a focus of particular concern, is a still evolving historical accomplishment. Referring to the reformist British political movement of Chartism in 19th century Britain, the noted historian of that period, Gertrude Himmelfarb, remarked:

> "The essential deprivation, however, the one crucial disability shared by all the poor, was their disenfranchisement. Under the terms of the Charter, this became the defining characteristic of the poor. And this was the historic achievement of Chartism. The social problem was redefined so as to make of it a political problem, the solution of which was… the integration of the poor into the polity… It was membership in that polity…that was now the coveted goal of the working classes and the poor."[1]

Here was a new effort to clarify and extend ideas of social membership. As with many ideas of social equity and fairness, there are complex conditions that effect how or if such commitments carry adequate explanatory power, and the degree to which they are usefully, captured, measured, *used*. Nineteenth century governments, in some ways uniquely up until then, faced the challenge of translating concerning conditions of marginalized individuals, into measurable, and actionable, categories and characteristics of society. Again, Himmelfarb:

[1] Gertrude Himmelfarb, *The idea of poverty-England in the early Industrial Age* (London: Faber and Faber, 1984), p. 268.

> "'Poverty,' like 'unemployment,' had the effect of moving the discussion from the subjective realm of persons to the objective condition that defined them. The emphasis thus shifted form the personal characteristics of the poor—their particular circumstances, characters, habits—to the impersonal causes of poverty: the state of the economy, the structure of society, the action (or inaction) of government, the institutions and forces affecting social conditions and relations." [2]

In part, the evolution of measures for poverty or unemployment took the form they did because the relationship between science and governance changed substantially as a part of the 19th century accomplishment of transforming the way states incorporated social welfare goals in Europe, and then beyond. Investment in measuring society as a way of capturing problems and furthering fairness in society made sense within a set of methodological accomplishments and expertise. These were themselves shaped by, and sought because of, their usefulness for creating shared actionable meanings thus permitting political responses to contentious issues.[3]

"Social inclusion" as a term of art arguably covers a wide and varying terrain.[4] One can read within one and the same definition that social inclusion reflects on the one hand, an individual's experience of self-actualization, as well on the other hand, things like the performance of legal institutions to equally apply the rule of law. These micro-macro stretches, however, are only a problem if not captured by facts that join them through hypothesis-driven verification and testing of such connections, the way for example measuring infant mortality is widely accepted to reveal something about overall health care system performance and living conditions. The current status of infant mortality as a key marker of overall health and adequacy of development was not a given, however. It was not obvious. It was, instead, laboriously constructed, involving consensus evidence and delineation of causal mechanisms relating this indicator with other conditions, as well as changes in moral attitudes regarding the relative responsibilities and contributions of individuals and society for health outcomes, and collective obligations to child success.[5]

The wide-ranging terrain of definitions of social inclusion or its key elements reflects its still early phase in becoming a fact—the degree to which defining this issue, and thus measuring it, is over-determined by value commitments, relative to hypothesis-testing.

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[2] Gertrude Himmelfarb, *Poverty and compassion-the moral imagination of the late Victorians* (Alfred A Knopf, 1991), p. 102.

[3] Theodore M. Porter, Trust in numbers- the pursuit of objectivity in science and public life. (Princeton: Princeton University Press, 1995).

[4] It is often at one and the same time an expectation of a basic level of well-being and opportunity for self-actualization for individuals within society, the receipt of basic necessities for all members of a given society, resilient structural features of societies that permit freedom of thought, political participation, and equitable, objective, application of the rule of law, the existence of civil society process and social institutions that facilitate such outcomes through enabling access to instrumental aids, and permit and promote cooperative and widely representative and participatory economies, resource access, and problem solving. Its notion of membership is also varyingly used- It can be used to concretely describe participation in political or social life and thus attention to procedural fairness in access to social goods, justice, and availability of forms of association and cooperation, or more *formal equity*. It also seeks to describe *substantive equity*—membership means some shared level of benefit, regard, opportunity.

[5] Richard Meckel, *Save the babies-American public health reform and the prevention of infant mortality,1850-1929* (Ann Arbor Paperbacks, 1998).

Measures offered as possible summary measures of inclusion tend to group specific indicators based on hypothetical logical fit within a preferred conceptual outline of "inclusion," rather than empirically derived clusters. In this way the measures are short hand descriptions of commitments—as opposed to factors that together indeed measure a distinct construct, a society's "Inclusion." Diversity of methodological rigor in this respect reflects and perpetuates the still unclear relation of measures to actions. How would an inclusion index be used? Do measures clearly identify the status of a modifiable "target(s)"?

Convincingly connecting the events of infant mortality to hypotheses about other social conditions and processes, were necessary in order to build and measure for actionable use, the fact of Infant Mortality. Many health indicators such as infant mortality, or the poverty level and unemployment rates, were not self-evident things. These indicators were assembled so as to do what modern facts do—to be "represented either as mere data…or as data gathered in the light of a social or theoretical context that made them seem worth gathering." [6]

Advocacy vs Actionability

Within this evolution of inclusion (or exclusion— a distinction that truly matters-yet is also regularly mixed) as a fact, advocacy and explanation can get confused. The 2007 UNDP Human development report-"Social inclusion in Bosnia-Herzegovina" (BiH), is perhaps one of the more ambitious efforts to date to develop a social inclusion measure and include it within a policymaking performance assessment and agenda-setting process.[7] It is also a good example of the significant work left to do. The Report presumes and advocates for inclusion as a driving purpose, and gathers features of society that might indicate inclusiveness. Despite the opportunity to do so, the Report does not prominently test the predictive value and explanatory power of its measure.[8] The measure thus appears as more a listing of characteristics and falls short of a "fact," a thing in itself, something measured through factors selected based on tested specified relationships with each other to explain hypotheses of interest, eg to empirically study hypotheses as to how inclusive practices might or might not *work*.

In illustrative contrast, a relatively deeper research base and literature has arisen on the similar topic of health disparities, for example differential health and mortality outcomes by race or income class. Attention to these categories of difference and how and why they effectively impact people's access to health services and health outcomes (not necessarily the same things) is, to be sure, driven by a sensitivity, advocacy and commitment to equity as a value. But effective, actionable responses to such differences

[6] Mary Poovey. *A history of the modern fact-problems of knowledge in the sciences of wealth and society* (Chicago U Chicago P, 1998), p. 96.
[7] BiH—UNDP, *Social inclusion in Bosnia and Herzegovina- National human development report* (2007).
[8] The report also then describes such an index as actually a measure of exclusion. This is potentially a distinction with a consequential difference. Attributing poor scores to an active exclusionary process rather than, as the notion of inclusion might suggest, to a wider range of circumstances, not necessarily purposefully created, but leading to a condition for some in the population of non-participation or access to societal benefits and protections, is a move that opens up potentially different remedial actions and culprits.

only in part rely on proactive inclusionary steps, or dismantling of exclusionary ones. For *disparities* in health care use, or rates of certain diseases by race, for example, to become *Disparities*, meant an ongoing process of hypothesis driven questions—eg, is the relative difference a reflection of specific structural barriers, disease patterns, geographic access, cultural health practices, geographic differences? How and with what relative power and or sequence do these factors mediate the outcomes of concern? Do they robustly add up to a set of robust connections such that Disparities carries with it an actionable model of a social process?

The features of exclusion listed the BiH exclusion index[9] combine descriptive conditions consistent with a state of exclusion, as well as the performance-status of society in actively making available the things one needs so as to be "included." Is inclusion, or exclusion, a state, or a trait? Should an index be organized around possible active marginalizing processes, and consequence states of poor access to social goods? Does that better position it to capture and describe social effects? What distinct validation power should we expect the items of any measure of Inclusion to demonstrate so as to distinguish measures that are self-fulfilling as plausible examples of the idea of inclusion (eg , having as a proxy for participation in social communication—having a phone) as opposed to how robustly they independently predict features and results of Inclusion? The index also mixes indicators with a relatively good foundation and understanding of how they relate to access, well-being and social goods, such as employment and education, [10] with more conjectural proxies. Without working out the explanatory power of measuring tools derived from conceptual commitments, any improvement in the Index Score of a given country or region has diminished assurance that such a gain actually means a broad change in the sorts of things meant by "inclusion." [11]

These uncertainties in the growing pains between advocacy and actionability, between a menu of social values, and grounding in measurable things, is to be expected. It does point specifically, though, to the important tasks facing a new policy-science community,

[9] The social exclusion index developed in the BiH Report identified key features of exclusion in the following domains: 1)living standards, 2) health status, 3) education;, 4) participation in society, and 5) access to services. Seven proxy indicators were used to reflect these, respectively: For living standards: the population below the income poverty line and long-term unemployment; for health: those without health insurance; for education: those over 15 years who did not complete primary school; for participation: those who do not vote in elections and do not participate in organized social activities, and for access to services: households without a telephone.

[10] AS Bhala, Frederic Lapeyre, *Poverty and exclusion in a global world* (Palgrave Macmillan, 1999).

[11] The DESA E-dialogue on measures for social inclusion, and related work, also pointed as models for measures of inclusion certain governance performance tools such as Sustainable Seattle or The Boston Indicators Project, but as these are more sustainable development or residential quality of life scales, it is unclear if their approach ultimately clarifies or confuses Inclusion. As with many such measures, items can risk having surface, but not tested reflection of the core concept at stake. So high turnover or high rental proportion vs stable ownership rates of neighborhoods could reflect "social cohesion," but left unanswered are both the degree such a measure of cohesion captures a thing-cohesion- and assurance that this thing, cohesion, is captured in such a way that in fact predicts or enables some strategy for other outcomes. The Boston data on turnover varies with respect to what it might mean with respect to the notion of cohesion. In one neighborhood, for example, it appears to reflect high student density, in another more unstable, poverty-driven rental instability. For a city like Boston that is explicitly invested in educational institutions as a foundation of its civic and economic development, the former is then a good thing. Furthermoire, the degree a label such as cohesion can interchange with that of inclusion or health, again reflects the as yet still working out of the core value commitments of the inclusion construct (I suggested *membership* as the core), and the degree with which posited index relate either to a consistent vision, or actionable and hypothesis-tested validity.

for which work in public health and mental health capacities and institutions, provide relevant examples, and concrete opportunities, that also map out significant next steps in building a science-policy nexus for Social Inclusion. Examples: include experience in identifying mediating factors between reliably measurable outcomes and larger social processes, and managing complexity through policy. Opportunities: include specific services and population effects, possible measurement strategies, capacities for managing complexity, engaging community participation, and being a uniquely regarded area of fairness and equity, and thus a wedge institution for furthering inclusive governance.

Building and testing models of social causes-Examples from health and mental health.

So, how well and in what ways might a given set of descriptive features that would seem to reflect inclusiveness, explain other indices of social success? A similar set of challenges are evident in the literature on a related idea—social capital, also often used in many ways, but intended to capture the degree to which the content, arrangement, access, and uses of social networks and group-held capacities contribute to community and individual success. As with inclusion, conceptual commitments as to what social capital is, vary, each with different methodological implications of how one knows it is "there." Social capital can refer to trust, participation, access, collective efficacy, skills, etc. [12] Think trust, and you might ask people if they feel they can trust their neighbor, or know someone who they can rely on to give them money if needed. Think collective efficacy, and surveys go out asking about how well people feel their expectations are realized in their surrounding community environment. Think participation, and people are surveyed as to how many organizations they belong to. These differing models hold up to the degree, not that they self-explain, but are relatively explanatory.

Work on the connections between social capital and health illustrates the importance in building such a construct, to relate it to otherwise important and policy-responsive outcomes of interest, in this case health. Efforts to relate social capital measures and mental health , for example, offer examples of a common critique of some social capital measures in that they are summary statements of individual perceptions or characteristics rather than measures distinctly reflective of how a given community or context is functioning as an entity in and of itself. The same efforts, however, also present an opportunity to overcome this challenge.[13] Innovative approaches are possible, such as coding observed relational and group behaviors in neighborhoods and looking at more

[12] Sampson RJ, Morenoff JD and Gannon-Rowlet T, "Assessing neighborhood effects: social processes and new directions in research. Annual Review of Sociology, 28, 2002, 443-478; Marybeth Shinn and Siobhan M. Toohey, "Community contexts of human welfare," Ann Rev. Psychol., 2003, 54: 427-59; Pickett K, Pearl M. Multilevel analyses of neighborhood socioeconomic context and health outcomes: a critical review," J Epidemiol and Community Health, 2001, 55: 111-122; Kawachi I. Social capital and community effects on population and individual health. *Ann NY Acad Sci* 1999;896:120-30; Sampson, R. J., S. W. Raudenbush; and F. Earls. 1997. Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science* 277 (Aug 15): 918; Lisa F. Berkman and S. Leonard Syme, "Social networks, host resistance, and mortality: a nine-year follow-up study of Alameda County residents," American J of Epidemiology, 109(2): 186-204; Ichiro Kawachi and Lisa F. Berkman, "Social ties and mental health, " Journal of Urban Health, September 2001, 78(3): 458-467.

[13] McKenzie, K. Social Capital and mental health. *BJP* 2002;181:280-283; Araya R., Dunstan F., Playle R., Thomas H., Palmer S., & Lewis G. (2006). Perceptions of social capital and the built environment and mental health. Social Science & Medicine, 62, 3072-3083.

aggregate features as opposed to individual characteristics (such as residential stability/mobility), and ratings of neighborhood life, collective efficacy, and built environments, show these factors might mediate mental health and health risks.[14]

Testing different measurement strategies that result from different commitments and conceptions of what relevant social capital is, against health outcomes, has introduced fertile critique, and theoretical and methodological change advances. For example, comparisons between different capital models for their relative value in explaining mental health outcomes[15]. The diversity of methods, evidence, and consequences that result from one or another version of social determinants may, as seen again in the testing ground of health outcomes, lead to paradoxical and contradictory findings with respect to presumed relevance and impact of such factors- ie high levels of participation by surveys in fact may reflect greater distress and anxiety. [16] So, building, challenging, and revising, construct validity through testing causal hypotheses (ie- "this feature of neighborhood social networks should impact health because…") against an established social good with a deep tradition of population measures— health and mental health— could be a model strategy for science-policy agendas that further salient measures of inclusion.[17]

Opportunities- Public health as a change and operational platform for exploring inclusion

"Mediators" and direct services

One crucial feature of research in exploring "neighborhood effects," social capital and similar macro-level social characteristics and processes, is the degree to which they identify and hypothesis-test the mechanisms, or "mediators," of health. It is through a plausible chain of mechanism that a grand social index gains traction. It often turns out,

[14] Yang Xue, Tama Leventhal, Jeanne Brooks-Gunn, Felton J. Earls, "Neighborhood residence and mental health problems of 5 to 11 year-olds," Arch Gen Psych, May 2005, 62: 554-563; Sampson RJ, Morenoff JD and Gannon-Rowlet T, "Assessing neighborhood effects: social processes and new directions in research. Annual Review of Sociology, 28, 2002, 443-478; Weich, S. et al. Mental Health and the built environment: cross-sectional survey of individual and contextual risk factors for depression. *BJP* 2003;180:428-433; Jan C Semenza, "The intersection of urban planning, art, and public health: The Sunnyside Plaza," American Journal of Public Health, September 2003, 93(9): 1439-1441.

[15] Trudy Harpham, Emma Grabt, Carlos Rodriguez, "Mental health and social capital in Cali, Colombia," Social Science and Medicine, 58(2004): 2267-2277; Rose R. (1999). What does social capital add to individual welfare? An empirical analysis of Russia. Social Capital Initiative Working Paper No. 15. Washington, D.C.: The World Bank; Silver E, Mulvey EP, Swanson JW, "Neighborhood structural characteristics and mental disorders: Faris and Dunham revisited. Soc Sci Med, 2002, 55(8): 1457-1470; Jason D. Boardman, Brian Karl Finch, Christopher G. Ellison, David R. Williams, James S. Jackson, " Neighborhood disadvantage, stress, and drug use among adults," Journal of health and social behavior, June 2001, 42(2): 151-165; Latkin A and Curry A. Stressful Neighborhoods and Depression: a Prospective study on the Impact of Neighborhood Disorder. *J Health Soc Behav* 2003;44:34-44.

[16] Caughy M.O., O'Campo P.J., & Muntaner C. (2003). When being alone might be better: neighborhood poverty, social capital, and child mental health. Social Science and Medicine, 57, 227-237; Johnell K., Lindstrom M., Melander A., Sundquist J., Eriksoon C., & Merlo J. (2006). Anxiolytic-hypnotic drug use associated with trust, social participation, and the miniaturization of community: A multi-level analysis. Social Science & Medicine, 62, 1205-1214.

[17] Hosman C, Jane-Llopis E, Saxena S, eds (in press) Prevention of mental disorders: an overview on evidence-based strategies and programs. (Oxford: Oxford University Press).

though with varying effect sizes, that such mediators are those quite familiar to community mental health and psychiatry such as familial transmission of coping, social transaction skills, certain harm reductions, capacity for resilience, parenting performance, community norm enforcement perhaps via principles of group process and cues for safety etc.[18]

Finding a "neighborhood effect" lets say that works through sustaining a social ecology of poorly networked single female parents, may not quickly lead to wholesale changes in what makes an area initially deprived. It may however, point to more readily available options that can address this mediating impact of fragile family and parenting systems by, for example, extending evidence-based parenting support and training strategies by a local or district health or mental health authority.

Beyond mediators, the fundamental purposes of health, and mental health, services is to address key causes of disability and mortality facing any, especially a struggling or high-conflict, society. The global burdens of disease on the productivity and resilience of societies are significant, and might be especially salient in those areas where inclusion-issues are also perceived as especially threatened. Depression alone, for example, is a leading cause of functional impairment and disability in both the developed and developing world, with some studies showing it rivals impairment due to chronic or serious infections diseases such as HIV, diabetes, or tuberculosis.[19] The mere presence of primary care services has been associated with a range of social capital outcomes.[20] Indeed, it has been argued that civil conflict and complex emergencies be "understood and approached within the broad context of public health since the manifestation of this pervasive social collapse are very high rates of death and morbidity from many causes…"[21] Several social determinant and social capital research areas point to mediating factors that can be addressed in part as extensions of public health work. A range of family, early childhood, school, workplace, peer, and parenting skill interventions, comprise a deep evidence base of population impact for preventing and ameliorating drivers of violence, depression, substance dependence, and cognitive potential.[22]

At a larger scale are also emerging efforts to apply behavioral science insights and extend community mental health services and expertise to a range of policies that involve

[18]Tama Leventhal and Jeanne Brooks-Gunn, "The neighborhoods they live on: the effects of neighborhood residence on child and adolescent outcomes." Psychological Bulletin, 2000, 126(2): 309-337;. Mark W. Roosa, Sarah Jones, Jenn-Yun Tein and Willa Cree, "Prevention science and neighborhood influences on low-income children's development: theoretical and methodological issues," American Journal of Community Psychology, 31(1/2) Mar 2003: 55-72.

[19] Murray, C. and Lopez, A. Alternative projections of mortality and disability by cause 1990-2020: Global burden of disease study. *Lancet*, 1997; 349:1498-1504.

[20] Albert Lee, "Improving health and building human capital through an effective primary care system," *Journal of Urban Health*, May 2007, Supplement, 84(3): 75-85.

[21] Sue Lautze, et al, "Assistance, protection, and governance networks in complex emergencies," *Lancet*, 2004, 364:2134-2141. p. 2138

[22] Hosman C, Jane-Llopis E, Saxena S, eds (in press) Prevention of mental disorders: an overview on evidence-based strategies and programs. Oxford, Oxford University Press; Clemens Hosman, Eva Jane` Llopis, Shekhar Saxena, *Prevention of mental disorders-effective interventions and policy options* (Geneva: World Health Organization, 2004); Jane-Llopis et al. Predictors of efficacy in depression prevention. BJP 2003; 183:384-397

at their root engaging psychological harms and processes. These could include roles in violence prevention, dialoguing and reconciliatory capacities, from small group to societal levels, as well as the value of social and interpersonal psychology of trauma research for crafting reconciliation and national reparations policies. [23]

Concrete public health functions overlap extensively with inclusive outcomes and work through inclusive strategies. In doing so, such functions would also get needed investment and be spurred to enhance effectiveness. Indeed a key outcome of a framework like inclusion should be to build on and use the capacities of such existing institutions. Doing so is particularly important so as to enhance a growth effect that can come from building Inclusion convergent with existing social welfare institutions and their functions. Development of Inclusion measures and practices should converge the purposes of such a framework, with the enhancement of, and on the foundation of, critical infrastructures, of which health and public health are particularly well matched.

While health institutions can certainly be used to discriminate and divide, they tend to be least defensibly used in that way. The fact that a diverse population still shares exposure to many health risks, the relatively better recognized need and expectation for an objective basis upon which to identify and distribute service according to scientifically-based or defined need and health services and health status, position health services and public health functions to be important wedge institutions for introducing and leading inclusive practice, and being perceived as legitimately expected to do so.

Measures

Public health practice encompasses several population measures that might be candidates to help cross-validate working concepts of inclusion effects. At the same time, as above, their use and familiarity among policymakers helps bolster the effectiveness and visibility of health work itself. Evolution of a social inclusion policy framework can thus be done in ways that at the same time showcase and bolster core public functions (ie, public health). Indeed this is an effect and purpose outlined by documents such as the BiH. But more attention is needed to developing a monitoring and measuring strategy that links the two purposes well. Summary inclusion "indicators" that rely heavily on proxy measures, mixing heterogeneous domains of social life as yet poorly modeled with respect to how they effectively interact, allow some general *indication* and comparability across areas and time. But, as has been argued here, they have yet to be established as valid summary variables.

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[23] Minu Hemmati, "Participatory dialogue- towards a stable, safe, and just society for all," Division for Social Policy and Development, UN Department of Economic and Social Affairs, 2006.; Anders Melbourn (ed) *Health and conflict prevention* (Madariaga European Foundation, 2006); Paula Gutlove, "Health as a bridge to peace: the role of health professionals in conflict management and community reconciliation," In D. Smock (ed) *Violence and health: Proceedings of a WHO Global Symposium* Kobe: Japan: World Health Organization, 2000; Ervin Staub, "Healing, reconciliation, and the prevention of violence after genocide or mass killing: an intervention and its experimental evaluation in Rwanda,"*Journal of Soc and Clin Psychology*, May, 2005; Brandon Hamber, "Narrowing the micro and macro: a psychological perspective on reparations in societies in transition," in Pablo de Grief, (ed) *The handbook of reparations* New York: Oxford University Press 2006), pp. 560-588; M. Brinton Lykes and Marcie Mersky, "Reparations and mental health: psychosocial interventions towards healing, human agency, and rethreading social realities," in de Grief, ibid, pp. 589-622.

Categories such as depression, post-traumatic and other generalized anxiety states, morbidity and functional impairment, and even general health and well-being, arguably have far greater construct validity than social inclusion, as well as a significant and growing body of work with respect to how they relate to each other and to actionable needs. Surveys such as the General Health Questionnaire (ie,GHQ-28) or the Medical Outcomes Study scales (ie, MOS-20) both strongly relate to levels of mental morbidity, as well as indicate general health status and well-being, have been used in conjunction so as to identify and cross-validate target needs, and are easily deployed at a population level, even in difficult environments such as recent post-conflict settings.[24]

A wide range of health indictors—infant mortality, preventable and infectious disease rates, among them—reflect access and coverage issues as well as relative vulnerability in society. Mental health indicators should be of particular interest to discussions about how to specify and track social inclusion targets precisely as they have the potential to both capture specific impairing conditions that can be addressed, as well as general features of well-being in a population. The issue is not to replace or re-define a social inclusion agenda as a public health one, but to appreciate, and leverage, the overlaps. Encouraging the use of population measures that support and enhance public health and mental health functions, but also capture larger aspects of social well being and functioning sought by the social inclusion agenda, "grow" the kinds of institutions at the forefront of inclusive practices, and also point towards next steps in the still uncertain evolution of inclusion indicators—that is, to use such health measures in hypothesis-driven model testing of actionable mediators of inclusion.

Managing complexity

Health care thus offers examples of complex social-model testing for multiple factor impacts and mediators, as well as specific institutions and services at the core of an inclusion agenda. It is also increasingly looked to as an area for development of governance that better manages the complex, cross-sector components that contribute to health:

> "The new public health is the totality of the activities organized by societies collectively (primarily led by governments) to protect people from disease and to promote their health… in a way that promotes equity…occur[s] in all sectors…ensure[s] that social, physical, economic and natural environments promote health…based on the belief that the participation of communities in activities to promote health is as essential to the success of those activities as is the participation of experts."[25]

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[24] DP Goldberg, VF Hiller, "A scaled version of the General Health Questionnaire," *Psychological Medicine*, 1979, 9: 139-145; JE Ware, Sherbourne, CD, "The MOS-36-item short-form health survey, I: Conceptual framework and item selection, *Medical Care*, 1992, 30:473-483; Wells, KB, et al, "The functioning and well-being of depressed patients: results from the Medical Outcomes Study, *JAMA*, 1989, 262:914-919; Barabara Lopes Cardozo, et al, "Mental health, social functioning, and attitudes of Kosovar Albanians following war in Kosovo," *JAMA*, August 2, 2000, 284(5): 569-577.

[25] From WHO's Ottawa Charter for Health Promotion, quoted in Fran Baum, *The New Public Health* 2ed. (New York: Oxford University press, 2002), 531.

Public health infrastructures not only capture expertise and responses to the sorts of mediating and impact effects of exclusion and marginalization, but there is increasing attention to the degree health functions are organizationally, as well as technically, capable of managing complexity and multiple systems/stakeholder responses. This is precisely the sort of capability needed to make sense of and react to inclusion measures.

Initiatives such as Healthy Cities seek to re-define the organizing issues, networks, and goals of government for health outcomes in a way that encompasses social determinants and benefits of health broadly construed.[26] Inclusion of health prevention in policymaking, such as Vic Health in Australia, realize new forms of policymaking and accountability for the multiple levels of social and government action needed for a health prevention paradigm.

Public health thus is a platform for the kinds of blending of policy paradigms central to the inclusion model, and the closer integration between research and practice. There are varied examples—the use of concept mapping, such as in one case example of tobacco control, to "promote better understanding of how to integrate research into practice, and a knowledge management map to guide use of information," and the growing field of applied health research integration.[27]

Community as focus

New forms of social-outcome driven governance also means looking at how and when to effectively leverage existing social networks and community participation. Models of community participation and advocacy as the basis for implementation of health service and prevention interventions, and participatory research and needs assessment, have long been of use and interest in public health.[28] One approach to inclusion indices, then, is deriving them from more locally specific measures. Participatory and local validation procedures can identify consensus on the features of experience and capacities of citizenship that inclusion seeks to capture and achieve. Here as well, the health field and health incidence research experience can be an exemplar, and laboratory, with which to

[26] Scott Burris, et al, "Emerging strategies for healthy urban governance," *Journal of Urban Health*, May 2007, Supplement, 84(3): 154-164; Jayne Parry, Ken Judge, "Tackling the wider determinants of health disparities in England: a model for evaluating the new deal for communities regeneration initiative," AJPH, April 2005, 95(4): 626-628.

[27] William M. Trochim, et al, "Practical challenges of systems thinking and modeling in public health," *American Journal of Public Health*, March 2006, 96(3): 538-546, p. 541; Stephen R Hanney, et al, "The utilization of health research in policy-making: concepts, examples, and methods of assessment," *Health research policy and systems*, 2003 1:2.

[28] Israel BA, et al "Review of community-based research: assessing partnership approaches to improve public health ," Ann Rev Public Hlth, 1998, 19: 173-202. Jackson, C, et al, "The capacity-building approach to intervention maintenance implemented by the Standford Fove-City project," Health Educ Rsrch, 1994, 9:385-396; Kenneth Wells, Jeanne Miranda, Martha L. Bruce, et al. "Bridging community intervention and mental health services research," Am J Psychiatry, June 2004, *161(6): 955-963.* Kuruvilla S. (2005). Civil society participation in health research and policy: A review of models, mechanisms and measures. Working Paper 251. London: Overseas Development Institute. Horsley K and Ciske, M. From Neurons to King County Neighborhoods: Partnering to promote policies based on the science of Early Childhood development. Am J Public Health 2005:95:562-567; Emilio Ovuga, Ted Boardman, Danuta Wasserman, "Integrating mental health into primary health care: local initiatives from Uganda, World Psychiatry, February 2007, 6(1)60-61.

shape and assess the consequences for governance, policy, and social development, of moving inclusion to Inclusion.