Social exclusion and mental health – how people with mental health problems are disadvantaged: an overview

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Abstract

Purpose – This paper aims to provide an overview of social exclusion and the way in which people with mental health problems are excluded from mainstream society in contemporary Britain.

Design/methodology/approach – The paper presents the main findings of the work of the Royal College of Psychiatrists Scoping Group on Social Exclusion and Mental Health.

Findings – An individual is socially excluded if he or she does not participate in key activities of the society in which he or she lives. People with mental health problems, particularly those with long-term psychoses, are among the most excluded groups in the UK. They may be excluded from material resources (poverty), from socially valued productive activity, from social relations and neighborhoods, from civic participation and from health and health services.

Originality/value – The findings of the Scoping Group provide an up to date view of the exclusion in people with mental health problems in the UK.

Keywords Mental illness, Social exclusion, Poverty, Inequality, Recovery

Paper type General review

Introduction

In 2008, the Royal College of Psychiatrists set up a Scoping Group to examine the nature of social exclusion and how it affects people with mental health problems and those with learning difficulties. The findings of the group were published as a position statement and as a book examining social inclusion and mental health (Royal College of Psychiatrists, 2009; Boardman et al., 2010). This paper summarises some of the main findings of the Scoping Group and their implications for mental health services.

What is social exclusion?

The term “social exclusion” belongs in the social policy literature and has emerged comparatively recently, however, its origins are much older. Social exclusion is one way of conceptualising disadvantage, traditionally seen in terms of “poverty”, “hardship”, “destitution”; all of which focus on material deprivation and the consequent personal distress of want and misery. These are matters that have been historically documented in the UK by, for example, the surveys of Rowntree (1901) and Booth (1889) and the later work of figures such as Townsend (1979). They also still part of contemporary life in the UK and have a day-to-day familiarity to people with mental health problems and those working in mental health services.

The modern use of the term social exclusion appears to have originated in France during the 1970s (Burchardt et al., 2002a; Morgan et al., 2007), referring to Les Exclus, people who have slipped through the net of the social insurance system and are thus administratively excluded by the state, such as disabled people, lone parents and unemployed people.
A helpful definition of social exclusion comes from the Centre for Analysis of Social Exclusion at the London School of Economics (Burchardt et al., 2002a):

An individual is socially excluded if he or she does not participate in key activities of the society in which he or she lives.

This definition highlights the central idea of participation and recognises that social exclusion is a relative concept, relative to the time and place in question. Importantly, this lays an emphasis on the lack of participation as being due to constraint, rather than choice.

There are, however, many competing views about the ways in which exclusion can arise, and these are liable to generate different types of policy outcome (Levitas, 1998). One view stresses the way in which poverty limits social participation and acts as a major cause of exclusion, compounded by other types of inequality the limits to exercising citizenship rights. Here, poverty is associated with a lack of material resources that restricts participation, and the resulting exclusion refers to:

[... the dynamic process of being shut out, fully or partially, from any of the social, economic, political and cultural systems which determine the social integration of a person in society (Walker and Walker, 1997).

We may be familiar with other views about exclusion, for example the idea of an “underclass” in which the emphasis is placed on the moral and cultural causes of poverty, with particular concern about the dependency of some on state benefits. Some concentrate on the social integration of people, often through paid employment.

In studying social exclusion, the examination of poverty (lack of participation owing to lack of material resources) remains important, but the range of phenomena are broadened to identify those whose non-participation arises in other ways, for example, through discrimination, chronic illness, social isolation and cultural identification (Burchardt et al., 2002b). Thus, exclusion examines multiple deprivations and broadens the range of indicators, whilst retaining the objective of identifying individuals who lack the resources to participate. In this way social exclusion has also been seen as a more comprehensive and dynamic concept than poverty, providing a change in emphasis rather than direction (Hills, 2002).

There are three central features to social exclusion (Burchardt et al., 2002b):

1. Relativity. Whether a person is socially excluded or included can only be judged in the context of their situation as a whole. Exclusion refers to a particular place and time. It can also be seen that exclusion is not absolute and can be considered as a matter of degree.

2. Agency. This refers to the fact that someone or something is doing the exclusion. Different views about the causes of exclusion tend to reflect differing views about agency or who is doing the excluding. Exclusion can be seen as the outcome of the system, with components of society, intentionally or unintentionally, acting as the excluding agents; including political, economic and social institutions. It is also concerned with power, with the excluded having a lack of autonomy or decision-making power.

3. Dynamics. Exclusion is seen as a dynamic process that operates across time, and potentially across generations. The causal models of exclusion are often not simple and represent the influences of the past (human, physical and financial capital) and those of the present (constraints and choices), with the individual influenced at many levels including family, community, national and global forces. The levels interact, outcomes result and these become present influences, which in turn feedback and affect constraints and opportunities. So, for example, a person may be excluded at one point in time because they lack work, but this exclusion could be exacerbated by the fact that they live in an area of high unemployment, that their family has been workless for many years and that there is a lack of future job prospects.

These ideas of social exclusion have influenced social policy, particularly in Europe and the UK Labour government of 1997-2010.
The relevance of social exclusion to people with mental health problems

Social exclusion and inclusion are not merely ways of describing the position of groups of people in relation to society; they have a direct link with concepts with moral and political connotations, particularly those relating to citizenship, justice, equality and human rights. Some of the ways in which these may be linked to the position of people with mental health problems are listed in Box 1.

Box 1. Central concepts of social exclusion relevant to people with mental health problems and learning disabilities

- A relative concept.
- Has been applied to a range of specific groups – including those with disabilities.
- Based on concepts of poverty and deprivation.
- Emphasizes agency and processes.
- Has a dynamic dimension.
- Central role of participation.
- Multifactorial causal framework.
- Life course and longitudinal perspective.
- Links to choice and access.
- Stigma and discrimination.
- Equality and human rights.
- Citizenship.
- Social capital.
- Recovery.

Recovery has been placed in this list. Whilst recovery is not usually seen as part of the literature on social exclusion, there is some overlap between the ideas of Recovery and the concepts of social exclusion. The ideas of recovery have largely emerged from the accounts of people who have experienced mental ill-health and may have used mental health services. They emphasise the individual nature of the process of recovery and the importance of hope, agency (control) and opportunity in fostering recovery (Repper and Perkins, 2003). The literature on social exclusion gives greater emphasis to social and political processes, their effects on the collective and the need for social, economic and fiscal policies to address change. However, Recovery and social inclusion may be linked by agency and opportunity: the opportunity to participate in one’s community and gaining a sense of control. In addition, many of the outcomes associated with recovery are also markers of social inclusion, such as working, studying, living independently, having good family relationships, having a social life, taking part in one’s own community. One way in which mental health services can contribute to the social inclusion of people with mental health problems is to develop practices and services that are “recovery-orientated” (Shepherd et al., 2008; Sainsbury Centre for Mental Health, 2009b).

Social exclusion in the UK

Over the last 30 years, the UK has become a more divided and unequal place. The UK has been likened to a camel train crossing the desert (Toynbee and Walker, 2008). The rich are at the front, those on low incomes at the back. Whilst the whole train is moving forward, those at the front move at a much faster pace than those at the rear, as the rises in their incomes have increased at a much greater rate. People with disabilities and those with mental health problems are over-represented in those travelling at the back of this train.

These gaps between rich and poor represent the rising inequalities in incomes seen in many western nations. The number of people living in poverty in the UK (defined as less than
60 per cent of the median income) rose during the 1980s and by 2008/2009 13 million people were in poverty (Parekh et al., 2010). Rises have also been seen in the number of children living in low-income households. These families have reduced access to what many others in society would consider to be essential items (Gordon et al., 2000). However, the incomes of those in the top 10 per cent have risen, and in particular those in the top 1 per cent have accelerated away in an unprecedented manner, contributing significantly to the rises in income inequality.

Social exclusion, as explained above, can generally be considered across several domains (Box 2). The poverty and social exclusion (PSE) survey carried out in Britain in 1999 showed that around 22 per cent of people were excluded in several of these areas and that people with longstanding illness and disability were at particular risk (Gordon et al., 2000). Probably about 5 per cent of the population is excluded persistently and in multiple ways. However, those surveys like the PSE, which take people living in households, may omit some people who are at most risk of social exclusion, such as those living in institutions, those in prison, children in local authority care or young offenders institutions, some disabled people, older adults living in residential homes, asylum seekers and the homeless. These groups are also vulnerable to developing mental health problems.

**Box 2. Domains of social exclusion**

- **Consumption** (exclusion from material resources): capacity to purchase goods and services (income poverty).
- **Production** (exclusion from (socially valued) productive activity): participation in economically or socially valuable activities (employment, education, etc.).
- **Social interaction** (exclusion from social relations and neighbourhoods): Interaction with family, friends, community (isolated networks).
- **Political engagement** (exclusion from civic participation): involvement in local or national decision making (having a voice, choice and control).
- **Service exclusion**: including utility services, public services, private services and health services.

**Why does social exclusion matter?**

Social exclusion contravenes the value of social justice and social solidarity. The extent of social exclusion in society emphasises matters of equality, rights, fairness and justice as exclusion shuts people off from opportunities, choices and options in life, which many others in society take for granted. It causes disruption and distress to individuals and families and to the community around them, and is costly to society not least because of the waste of human potential.

We know that the domains of exclusion listed in Box 2 are interlinked and affect individuals and families. For example, poverty is associated with worklessness, financial problems and debt, which may lead to housing problems, relationship conflict and breakdown and ill health due to stress. Lack of education and skills increases the chances of being unemployed and having a poor earning capacity. Poor housing is associated with ill-health, family and school disruption and increased risk of being on the Child Protection Register.

These inequalities are cumulative over an individual's lifetime and may be carried from one generation to the next. They may reinforce barriers to children getting ahead in later life and contribute to experiences of worklessness, offending behaviour, mental health problems or institutionalisation. Children born into the particularly disadvantaged households are at particularly high risk of these problems. For example, 22 per cent of children born to the 5 per cent most disadvantaged families had multiple problems at age 15 years, compared to 0.2 per cent of children born to the 50 per cent most advantaged families (Fergusson et al., 1994).

In the UK, there have been a number of important studies where a sample of children born in a given year has been followed up over many years (Sainsbury Centre for Mental Health, 2009a). These cohort studies provide valuable ways of looking at the effects of early
experiences on later life chances. For example, the 1970 cohort showed a strong link between a person’s social class at birth and the probability of multiple deprivations by the time they reached the age of 30 years, with those from social classes IV and V having much greater chances of deprivation than those in class I and II (Feinstein, 2008). Social class at birth is also linked to the cognitive development of children (Feinstein, 2003) with poor cognitive performance at age 22 months improving in children born into more privileged families, but not in those in disadvantaged families. Notably, the cognitive functioning of more able children in these disadvantaged families at 22 months may decline by age ten years.

Importantly, exclusion is linked to ill-health. Several important reports have highlighted the problems of health inequalities internationally and in the UK (World Health Organization Commission on Social Determinants of Health, 2008; Marmot, 2010). In general, disease and death are more common in deprived people and these inequalities in health in the UK widened during the 1980s and 1990s and have not decreased over the past 15 years. Inequalities in life expectancy between poor and rich areas of the UK widened in the first years of the twenty-first century and have exposed some stark inequalities, for example in the Calton area of Glasgow the life expectancy at birth for men is 54 years, whilst in Lenzie only a few kilometres away it is 82 years (Shaw et al., 2005; World Health Organization Commission on Social Determinants of Health, 2008).

Over the past 20 years has been the increasing awareness that whilst poverty is directly related to poor health (including mental health), in rich countries it is the inequalities of income within these countries that are most strongly related to life expectancy and levels of morbidity, mortality and wellbeing, with average income level having a much weaker relationship to ill-health (Wilkinson and Pickett, 2009). This implies a limit to the effects of improving overall income level beyond which they have little effect on health and suggest that just raising the living standards of the poorest will not reduce these inequalities in the absence of attempts to reduce the inequalities in wealth. This is particularly pertinent in the UK with its unprecedented increases in income inequality since the 1970s and may explain the failure to improve health inequalities over that period. Inequalities in income are also related to levels of violence and trust in the general population. Income inequality is also strongly associated with the prevalence of mental health problems in the population (Pickett and Wilkinson, 2010).

Mental health and social exclusion

There is compelling evidence that people with mental health problems and people with learning disabilities are at risk of exclusion. This applies across people with all types of mental health problems and across all age groups. However, we are all aware that people with mental health problems are not a homogeneous group and have a range of incapacities and have varying risks and experiences of exclusion. Notwithstanding individual differences, it is generally clear that some groups are particularly at risk of exclusion, particularly those who experience psychoses and those whose problems fall into multiple diagnostic categories. In addition, some people by the nature of their situation are automatically excluded, these people include prisoners, those who are homeless and refugees and asylum seekers. People in these groups are particularly at risk of mental health problems.

In general, people with mental health problems are more likely to be excluded in one or more of the domains listed in Box 2.

Exclusion from material resources

People with severe mental illness often live in material poverty; they have less income and more debt and financial hardship than those without mental health problems and rely on welfare benefits (Jenkins et al., 2008). People with common mental health problems are less likely to be on benefits than those with psychoses and generally have higher incomes, but compared with the general population adults with common mental health problems are twice as likely to be receiving income support and four-five times as likely to be on invalidity benefit.
Poor children are much more likely to experience mental health problems than those living in more affluent families, for example the likelihood of having a diagnosable mental health problem is three times higher for children in the lowest income household than in the highest earning group (Green et al., 2005).

The consequences of a low income include reduced access to basic necessities, lack of capital resources, a reduced ability to save, likelihood of debt and poor access to social outlets. It is also associated with living in poor neighbourhoods, poor housing conditions and personal safety.

In the PSE survey, more than a third of people who need, but are unable to afford, material necessities experience poor mental health and almost 60 per cent of people with mental health problems describe themselves as ‘feeling poor all the time’ (Payne, 2006). They may not be able to afford basic necessities, such as adequate heating and domestic appliances, holidays and common social activities may be seen by them as luxuries. They are unlikely to have any significant savings or capital and often do not have a bank account. They may also be in debt and unable to afford insurance or other financial services (Fitch et al., 2007; Jenkins et al., 2008). The low income of people with severe mental health problems may restrict their travel opportunities as most will not be able to afford a car, discretionary transport or holidays. This reinforces isolation and may also affect access to services.

Personal poverty and deprived neighbourhoods tend to go together and are associated with mental health problems. Rates of criminal victimization are higher in these areas, which lead to increased fear of crime, social withdrawal and mental health problems amongst direct victims and non-victimized residents. Poor housing is often an obvious feature of these neighbourhoods.

Most people with severe mental health problems live in social housing (owned by local authorities or registered social landlords). Compared to the general population, people with common mental health problems are one and a half times more likely to live in rented housing – with higher uncertainty about how long they will remain in their current home (Meltzer et al., 2002). They are twice as likely to say that they are very dissatisfied with their accommodation or that the state of repair is poor, and four times more likely to say that their health has been made worse by their housing (Meltzer et al., 2002).

Exclusion from productive activity

In general, there is an association between low levels of education and mental health problems. Many diagnosable mental health problems begin early in life and as a consequence may have an impact on educational attainment. This often results in disadvantages in acquiring skills, impairment of life chances during adulthood and loss of human capital. Over half of people with a diagnosis of a psychosis have no educational qualifications.

Rates of employment in people with mental health problems are lower than in the general population. For people with a diagnosis of schizophrenia it is between 10 and 20 per cent, but may be much lower in some areas (Marwaha and Johnson, 2004). People with common mental disorders have higher rates of employment, but lower than in the general population.

Exclusion from social relations and neighbourhoods

In general, people with mental health problems are more likely to be socially isolated than others in the general population and are likely to have reduced interaction with others and low access to opportunities and facilities in the community. This is particularly the case for people with severe mental health problems.

Poor social networks have long been recognised as a risk factor for mental health problems. People with common mental health problems generally have low-social support and people with psychoses have even lower levels. Adults with severe mental health problems are five times, and those with common mental health problems twice, as likely to report a personal severe lack of support as those with no illness. People in contact with mental health services are relatively isolated and are likely to derive many of their social contacts from other service users.
Children who grow up in a climate of social adversity, family dysfunction and breakdown often have difficulty successfully integrating into society which will be hampered by the presence of diagnosable childhood mental health problems. Some types of disorder are particularly destructive in later life. For example, children with disruptive behaviour face a number of poor outcomes: they are more likely to show poor educational attainments and drop out of school; leave their homes and families at younger ages; and have poorer early work histories with higher risks of unemployment. They are also more likely to enter romantic and sexual relationships earlier, and experience more difficulties and breakdown in those relationships; become pregnant or father children earlier than their peers; be involved in crime; and have poor general health in their early adult lives (Maughn et al., 2004).

In general, people with mental health problems are less likely to participate in social leisure activities than the general population. Some of this may be related to the nature of the disorder, but structural barriers such as lack of opportunity, limited income and discrimination also play a part. Overall, less affluent people are less likely to take part in active leisure activities than those better off. Little detailed information is available on how frequently people with severe mental health problems access mainstream social and leisure facilities, but experience suggests that these opportunities are restricted.

**Exclusion from civic participation**

There is a general lack of information about the involvement of people with any sort of mental health problems in local or national decision making (having a voice, choice and control). However, it is likely that civic participation is reduced in people with mental health problems. There is some evidence about curtailment of citizenship, political and human rights for people with mental illness (Thornicroft, 2006; Sayce, 2000), for example in the right of inpatients to vote, and for people with mental health problems to serve on juries (Rethink, 2010).

**Exclusion from health and health services**

People with all forms of mental health problems are at increased risk of premature death from natural and from unnatural causes (Harris and Barraclough, 1998). A Disability Rights Commission (DRC) general formal investigation in 2006 found that people with significant mental health problems experience a “triple jeopardy”, that is they are more likely to get heart disease, diabetes and some cancers, especially when young and, once diagnosed are more likely to die within five years. In addition, they experience poorer quality healthcare than people without mental health problems. People with a diagnosis of schizophrenia, bipolar disorder or depression die younger than other people; they have significantly higher rates of obesity, smoking, heart disease, hypertension, respiratory disease, diabetes and stroke and breast cancer than other citizens (DRC, 2006).

**Mental health and social exclusion – causes**

How can we understand the relationship between mental health problems and exclusion? The conditions of exclusion may be seen as a cause of mental health problems or may be a consequence. Multiple pathways lead to the same outcomes. Some “causes” may work in both directions, for example deficits in close personal relationships may be a cause and a consequence of mental health problems. There may be many “third variables” – for example, poverty may be seen to contribute to both a lack of social participation and mental illness. Three major social variables can be considered to have a causal influence in “driving” social exclusion: poverty; lack of social capital; and stigma.

Some factors put people with mental health problems at greater risk of exclusion: age, gender, ethnicity, educational disadvantage, worklessness, an adverse family background, history of contact with the criminal justice system and chronic physical ill-health. We must also consider the way the mental health condition might be disproportionately affected by certain kinds of losses or restrictions relating to income, health or reduced social ties. There may also be cumulative disadvantages which are acquired across the life course, for example disrupted family and social relationships early in life may mean that individuals lack
emotional and instrumental support in mid- and later life. Characteristics of an individual's community may be important – for example, residence in some urban communities with high-population turnover, declining socio-economic status and rising levels of crime and insecurity may undermine individuals' ability to maintain stable social relationships. Finally, there is an impact of discriminatory behaviours and policies in producing exclusion of people with mental health conditions.

To these conditions, there is the addition of dynamic factors in generating exclusion. People may be pushed into exclusion by trigger events such as loss of employment; development or relapse of mental health problems or physical illness; discharge from hospital or release from prison. Risk factors and trigger factors may interact. There may be “cycles” of social disadvantage, whereby historical factors (such as family disruption, educational disadvantage, poverty) contribute to poor social outcomes (exclusion, mental ill-health) and these then contribute to further disadvantage in the future. Opportunities thus may be limited early in life owing to, for example, being born into poverty or with a learning disability or may arise later. Over the life span opportunities may be lost, limited or wasted through circumstances that have arisen or through people's own actions. There may be a “multiplier effect” for social disadvantage. For example, having three risk factors together carries more than three times the risk of each added together – this may reflect an “amplification” of social disadvantage, perhaps through the negative effects of stigma on wellbeing and resilience, which means that the most disadvantaged are cumulatively disadvantaged.

Conclusion

Social exclusion is a key social problem in British society. There is a wealth of evidence to support the contention that people with mental health problems and those with learning disabilities are excluded from participation in many areas of society. The size of this problem is huge, not least because mental health problems have a high prevalence, but also because of their high personal, social and economic cost.

The prominence of structural factors in driving exclusion implies that without attention being given to such matters as income inequality, poverty, employment, education, housing, communities, rights and social justice there may be little chance of improving the status and outcomes of those with mental health problems. These can only be addressed by economic and social policies. Nevertheless, mental health services can play their part through paying greater attention to the creation of services that are recovery-orientated.

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