SOCIAL EXCLUSION AND THE WAY OUT
An individual and community response to human social dysfunction

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Kent Institute of Medicine and Health Sciences, University of Kent, UK

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ABOUT THE AUTHOR

Dr Adrian Bonner is Reader in the Institute of Medicine and Health Sciences, University of Kent. As founder and director of the Addictive Behaviour Group he has facilitated the development of undergraduate and postgraduate teaching and research activities aimed at practitioners and managers working in social and healthcare services. He has been a member of various UK government working groups, including Skills for Health, a workforce development group set up to support the UK Anti-Drugs Strategy and is a director of the Institute for Alcohol Studies. Adrian's principal research has focused on mechanisms of brain damage and the role of nutritional factors in cognitive function. This biomedical research has become more integrated with psychological and social approaches during the development of innovative screening, assessment and outcome monitoring systems for use in the delivery of services for vulnerable people.

Adrian provides health-related support for The Salvation Army Social Services in the UK; he also represents The International Salvation Army on various bodies, including the United Nations (UN).

PREFACE

Social Exclusion and the Way Out is an attempt to provide a critical appraisal of the complex nature of social exclusion, which has not changed, in many ways, since the nineteenth-century philosophers began to diagnose problems of the 'deserving and undeserving' poor. In 2006 poverty still exists but, in the analysis of the social dimensions of poverty and social exclusion, it is essential to focus on the nature of human dysfunction. Irrespective of an individual's income and wealth or poverty, the person's perception of their *social identity* and *quality of life* will be significant determinants of their response to their social situation. One of the long-lasting objectives of The Salvation Army's Social Services is to *work with people where they are* and to help them develop a sense of *meaning and belonging*. Hopefully, a greater understanding of individual functioning and the underlying issues of mental health, illness and the pervasive problems of alcohol dependency will provide some insight into new ways of identifying individual needs and help to inspire new interventions to support the vulnerable members of the community.

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INTRODUCTION

In the second half of the nineteenth century poverty was a political and moral issue. A social consequence of the industrial revolution was the growth of slums in the shadows of the factories and warehouses, in the expanding English towns. In the country the paupers were thought to have the opportunity to help themselves out of poverty, but in the industrial towns destitution was considered to be inevitable. The malnourished and disease-ridden urban populations were becoming a growing problem. From a health perspective only a third of the men who took the 'Queen's shilling' passed a very basic medical examination (Himmelfarb 1984). Marx, Ruskin and other philosophers at the time warned that poverty would be the catalyst of a revolution. Prior to the publication of *Das Kapital* by Marx, Engels (1844) had written *The Conditions of the Working Class in England* and Henry Mayhew had published *London's Labouring Poor* in 1850.

Charles Booth's 30-year survey of the causes of poverty, published in *The Life and Labour of the People of London*, added to this concern that something must be done about the growing problems within urban society. Booth used a rational scientific approach to diagnose the problem, but made a limited attempt to provide a solution to the complex range of problems that he observed. He classified the population of London according to their poverty or affluence, and concluded that 8.4% of people in London lived in very poor conditions, 'at all times more or less in want'. In East London he found 35% in poverty. Charles Booth's finding was that 'those deemed very poor [class B, in his survey] . . . were of a wretched and casual character . . . and . . . at all times more or less in want', and he suggested that they should be removed from the society of the deserving poor, 'to prevent them from infecting industrious workers with their feckless ways'. Booth suggested that, 'they should be placed in state-created communes where their children, temporarily separated from their parents, would be educated to become useful members of society'. Despite this capitalist-based view of the contemporary social problems, Booth did comment on the observation that only 30% of the households in London included grandparents, whereas in Barking, Essex, families showed 'a very wonderful and beautiful loyalty to parents in households . . . which was clearly lacking in London'.

The work of the Rowntree Foundation began at this time, with Seebohm Rowntree attempting to define poverty more precisely than Charles Booth

had done. Rowntree described 10% of the working-class households in York as living below the poverty line in *primary poverty* and 17.93% were living in *secondary poverty*, defined as living above the poverty line but 'obviously living in a state of poverty . . . in obvious want and squalor'. (For more information on these early studies on the urban and rural poor, see Thane, 1982 and Chapter 1.)

In his book about the lives of William and Catherine Booth, Roy Hattersley (1999) has provided a useful review of the socio-political events of this period and has observed that William Booth (1829–1912) did not have the analytical skills of his unrelated peer Charles Booth, but that he was concerned with the linkages between moral and physical degeneration, poverty and depravity. William was energetically engaged in evangelical and social enterprises and founded The Salvation Army (originally called the Christian Mission) in 1865. The Christian Mission set up soup kitchens in the 1860s and the 'social ministry' expanded to provide 'shelters' for men and 'refuges' for women. William's helpers' expression of social action was to provide cheap food and material help for the poor. Despite considerable opposition from the establishment for these evangelical and social welfare activities, The Salvation Army's social services expanded. William was very disturbed at finding the existing social policies of the day to be 'lamentably inadequate' – a new radical approach was needed.

Using the model of Henry Morton Stanley's accounts of his travels across Africa in *Through a Dark Continent*, William Booth documented his radical strategy to 'present help for the actual need' in a far-reaching and, what appeared at the time, aspirational strategy of nearly 300 pages, published in 1890. The book was entitled *In Darkest England and the Way Out*. This wide-ranging set of observations, certainly informed by Charles Booth and other commentators at the time, provided innovation and far-sighted approaches in addressing prostitution and other social ills, and was based on an impressive 'Great Scheme', which included three parts.

The first component of the scheme was the 'city colony', a refuge in the 'very ocean of misery'. The city colony consisted of shelters, where the destitute were to be taken, provided with food and shelter and exposed to 'moral and religious influences'. Access into a shelter required a small payment, obtained by work either in a Salvation Army enterprise or as a temporary day labourer sent out by a Salvation Army employment service to employers friendly to the scheme. The plan was that most men who passed through these agencies would be 'floated off to permanent employment'. Those who remained with the Salvation Army would be checked for 'health and character' and sent to the second part of the Great Scheme, the 'farm colony'. Personal improvement from the benefits of a healthy rural environment, supplemented by 'industrial (agricultural) . . . moral and religious methods' would equip the men to return to their earlier honest employment or to settle in the country as

agricultural labourers. It was expected that the majority of 'reclaimed' men would be transferred by the Salvation Army authorities to the third part of the scheme, the 'overseas colony', where they would be assisted to emigrate to Salvation Army agricultural communities to be established in underpopulated British colonies, such as Canada, Western Australia and South Africa, 'the final home for these destitute multitudes'. A print of the fascinating coloured picture showing the ocean of misery, a lighthouse, and the city, farm and overseas colonies overlaid with a large amount of demographics describing the main socially excluded groups (of criminal, homeless, prostitutes, etc.) was included in *In Darkest England and the Way Out*.

This book was more than an aspiration strategy as many of these ideas did materialise. By 1890, not only had a considerable number of shelters/hostels been established, but The Salvation Army also opened its first labour exchange in the East End of London and within the year 20 similar exchanges had been established throughout Britain. Expansion into the United States and many other countries was even faster (Bollwahn 2000). In 2007 The Salvation Army is one of the two largest social support agencies working collaboratively with the US government in many hundreds of community projects. A similar situation exists in Australia, Sweden, Norway and many other countries.

One of the common features that seemed to be exacerbating the problems of the vulnerable people was alcohol abuse. In *In Darkest England and the Way Out* Booth comments: 'drunkenness . . . nine tenths of our poverty, squalor, vice and crime spring from this poisonous tap-root. Many of our social evils, which over shadow the land like so many Upas trees (poisonous) would dwindle away and die if they were not constantly watered with strong drink'. The many Salvation Army programmes addressed the problem of alcohol dependence in various ways, but an abstinent approach was used throughout this work. At this time the Temperance Movement attracted more members, became a mass movement and helped to create an ethos now described as *social capital*. Although often regarded as an outdated approach to managing the problems of alcohol in society, Virginia Berridge (2005) argues that the various expressions of *temperance* provide important models for developing current strategies in 2007.

William Booth's legacy in 2007 is an organisation operating in 111 countries with some very impressive statistics, which include: 31 769 beds in residential hostels; 10 333 beds in emergency lodges; 206 children's homes (capacity 9377); 175 homes for the elderly (capacity 12 036). Over the years specialist alcohol dependence services have been established. Currently there are 71 non-residential programmes (with a capacity of 2383), 209 residential programmes (with a capacity of 12 513), 40 Harbour Light centres (with a capacity of 3951), and 44 other services (with a capacity of 3716). More detailed international statistics are given in Appendix A.

William Booth was one of several social reformers, including Shaftesbury, Rowntree and Barnardo, whose ideas began to shape the community response to poverty alleviation, and address the links between moral and physical degeneration in England and other countries. Booth's influence can be measured in terms of the many millions of people who have directly benefited from this unique form of social action.

This volume is dedicated to the work of William Booth and to the current 25 000 officers, 110 000 staff and approximately 1.5 million members and volunteers of The Salvation Army, which still provides help for the 'submerged tenth of the population'. In the developing world the 'submerged tenth' refers to those in absolute poverty; in the developed world the 'submerged tenth' includes those in relative poverty but who are socially excluded.

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ABOUT THIS BOOK

Social exclusion is a highly complex phenomenon that involves a wide range of complex needs. From a holistic viewpoint individual needs will be highly specific and require a detailed assessment of the individual's particular health and social circumstances. To tackle the problems of *social exclusion*, therefore, a multidisciplinary evidence-based approach is required. The main disciplines contributing to this approach have arisen from the biological sciences (including medicine, psychiatry, psychopharmacology, health, ethology), psychology (including social psychology, perception, cognition, learning, developmental psychology) and social science (including socialisation, deviance, social policy, economics). All of these subdisciplines could potentially contribute to the *biopsychosocial* model of social exclusion. Each of these areas of enquiry has its own language and methodology, leading to problems in interdisciplinary communication. This book is an attempt to provide a link between these approaches by considering the nature of *meaning and belonging*, from a multidisciplinary perspective. As a number of the concepts contributing to this *biopsychosocial* model are complex, many of the sections are cross-referenced to other sections of the book where fuller explanations are provided.

Parts I and II of this book provide an overview of the mechanisms and functions of social groups and some speculations as to the reasons why some individuals do not function well within a social context. The term 'complex needs' is frequently used to describe the range of interacting problems that mitigate against inclusion. In some people, addressing one problem, for instance deficits in basic skills, might unlock a combination of complex needs. Stigmatisation, despair and hopelessness, exacerbated by poverty and poor living conditions, can lead to social exclusion. However, inclusion problems can occur in those who are materially well off and have access to adequate resources. In both of these situations motivational issues, compounded by physical and mental health problems, need to be understood and appropriate interventions offered. The main theme being developed in Part II is the link between biopsychosocial aspects of stress, which, if it becomes chronic, can lead to mental illness and problematic alcohol and drug misuse. These negative health behaviours become reflected in

lifestyle choices, which can be destructive, for instance inadequate feeding and other aspects of personal organisation. There is increasing evidence of problematic alcohol and drug use affecting neuropsychological functioning. This linked set of actions and consequences underpins the cycle of social exclusion; this is particularly significant from a transgenerational perspective in view of the developmental sequelae, which is commonly found in socially deprived communities.

Part III consists of a brief review of statutory and non-statutory responses to the complex needs of the socially excluded, which have developed during the last two centuries. Well before the establishment of the welfare state the community responded to vulnerable people in a variety of ways, many of which were aimed at protecting the community. Nevertheless, care of the needy was gradually recognised as a function of a civil society. The welfare state developed as a consequence of the actions of benefactors and social reformers and also as a response to the consequences of industrialisation.

Part III begins with an introduction to screening and assessment. The need to clearly identify the primary and secondary causes of social exclusion is a prerequisite for the development of appropriate services and the creation of a programme of support for the client. In developing either statutory or non-statutory support services the guiding philosophy of the project/service needs to be carefully considered in order to provide the most effective support to enable the service user to change his or her behaviour, and become motivated to step out of the exclusion trap and be included in mainstream society.

The process of change and limitations due to neurocognitive deficits is the main topic of Chapter 11. Here the link between psychosocial interventions, brain function and nutritional deficits in the socially excluded is highlighted. Chapters 12 and 13 present the highly complex and ever-changing health and social care infrastructures in the UK. The reader will notice the evolving socio-political attitudes to the 'deserving and undeserving poor' during the last two centuries. Currently the speed of health and social care reform appears to be increasing, by the month. Although the initiatives from the Department of Health, Department of Work and Pensions, the Office of the Deputy Prime Minister and other departments are well documented on government websites, this section of the book is intended to highlight the main changes and place these within an historical context. An emerging theme in these chapters is the creation of very large governmental budgets and the apparent state intervention in providing support that was previously generated by the community. Statutory interventions are expensive and not always the most appropriate ways to engage with hard-to-reach vulnerable people. A way forward appears to be the development of partnerships between public-financed and voluntary sector organisations.

Some readers of this book might wish to use a 'pick and mix approach', for instance those who are less familiar with life science perspectives might find it useful to read Part I, followed by Part III, and then explore the more detailed aspects of Part II.

The author hopes that this wide-ranging approach to social exclusion will provide an important insight into *meaning and belonging* in the UK in the twenty-first century.

Part I

Individual Functioning and Social Exclusion

CHAPTER 1

EXCLUSION FROM SOCIETY

WHAT IS SOCIAL EXCLUSION?

Early definitions of social exclusion were quite broad and described the consequences of the associated problems of unemployment, poor skills, low incomes, poor housing, high crime, bad health and family breakdown. The UK government's Department of Culture, Media and Sport used operational definitions such as:

> Social exclusion takes many forms. It can be direct or indirect, and can embrace both groups and individuals. Exclusion also has a geographical dimension embracing rural, urban and suburban areas alike (DCMS 1999).

The government's definition of social exclusion was extended in 2001 to include:

> Social exclusion is something that *can* happen to anyone. But some people are significantly more at risk than others. Research has found that people with certain backgrounds and experiences are disproportionately likely to suffer social exclusion. The key risk factors include: low income; family conflict; being in care; school problems; being an ex-prisoner; being from an ethnic minority; living in a deprived neighbourhood in urban and rural areas; mental health problems, age and disability (DfES 2005).

Although UK government definitions have been broadened during recent years, social exclusion is still couched in anti-poverty work. Percy-Smith (2000) has argued against the narrowing of definitions to poverty and spatial issues, she defines seven 'dimensions' of social exclusion:

- Economic (e.g. long-term unemployment; workless households; income poverty).
- Social (e.g. homelessness; crime; disaffected youth).
- Political (e.g. disempowerment; lack of political rights; alienation from/lack of confidence in political processes).
- Neighbourhood (e.g. decaying housing stock; environmental degradation).

- Individual (e.g. mental and physical ill health; educational underachievement).
- Spatial (e.g. concentration/marginalisation of vulnerable groups).
- Group (concentration of above characteristics in particular groups, e.g. disabled, elderly, ethnic minorities).

Social exclusion policies should address the needs of groups and individuals, as listed above, and those who do not have access to the relevant support services, and are disempowered from civil society. Social *inclusion* occurs when those in need engage with and begin to benefit from statutory and nonstatutory support structures and services. However, inclusion involves more than 'support', participation in the community is a key aspect of *meaning* and *belonging.*

Social cohesion or *community cohesion* are mechanisms for creating a society that is not fractured by poverty, racism and violence. However, it is important to keep the individual as the central focus. This is engendered in the concept of *capacity building*, which promotes the idea that it is the ability of people to equip themselves and bring about local change. This latter approach comes from within communities (cf. externally led initiatives). In discussing the community response to HIV/AIDS, Campbell and Campbell (2005) suggest that sustained change comes from the learning experience of the community and the capacity of the individuals to believe in their ability to overcome the challenge. One of the principal factors in the exclusion of HIV/AIDS and other disease-related problems such as leprosy is *stigma.*

SOCIAL POLICY PERSPECTIVES ON SOCIAL EXCLUSION

In the first part of the nineteenth century socialists, such as Robert Owen, and conservatives, such as Thomas Carlyle, were beginning to analyse the unequal distribution of wealth and income being generated from industrial capitalism. They identified strength originating from competitive rather than cooperative effort and self-help emerging at the expense of mutual obligation and responsibility for the poor.

These ideas were influential in organisational management and the political establishment supporting the Poor Law Amendment Act of 1834, described by Engels as 'the most open declaration of war by the bourgeoisie upon the proletariat' (Engels 1944). The implications of this act were that anyone who was physically capable of work had no alternative but to support him/herself. Public help was only given to the aged and disabled. The view at that time was that there were sufficient employment opportunities for everyone, but if not, other developing economies in America and Australia provided opportunities in this *laissez-faire* view of the international economic community.