

Thoughts on vulnerable groups and social exclusion

Conclusion

The Social Exclusion Unit referred to “what can happen when individuals or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, poor environments, bad health and family breakdown.”

Poverty is defined on a continuum; Joseph Rowntree has two clear levels;

1. A household is deemed to be in poverty if its income is less than 60% of median household income for the year in question, also referred to as the poverty line
2. The second level was of “deep poverty” (household income at least one third below the poverty line). In 2008/09 a record number of people, 5.8m were in deep poverty.

Peter Townsend (1979) argued that poverty is not just about subsistence but also in terms of people’s ability to participate in the customary life of society. He referred to poverty when “... the resources are so seriously below those commanded by the average individual or family that they are in effect excluded from ordinary living patterns, customs and activities.” His definition of resources included cash incomes but significantly he also referred to collectively-provided services.

People who are vulnerable to poorer health outcomes as a result of poverty and exclusion.

Any person

Those in households in poverty, particularly deep poverty.
Households without work for two years or more
Limiting long-standing illness or disability
With histories of poor mental health
Who lives alone
Disrupted family or social network

Children as above plus

Low birth weight babies
Poor or irregular attendance at school, incl exclusions
Pupils gaining no GCSE grade C or above
Girls conceiving under age 16
Young offenders
Know to social services or CAMHS

Young Adults as above plus

NEET 16-18
Leaving care
Starting drug treatment
Without basic qualification (at 19)
With a criminal record (at 23)
Homeless or rough sleeping
Sexually exploited

Older people as above plus

Anxiety or dementia
Carer 65-84
Help from services to maintain independence, to live at home

Communities

IMD LSOA ranking
Lacking a bank or building society account
Non-participation in civic organisations
Vulnerability to crime, victim or perpetrator
Homes lacking central heating
Households in temporary accommodation
Rough sleepers
Overcrowding
Mortgage arrears
Membership of an oppressed group for example, BME ,
LGBGT

Developing a risk-based approach

A pragmatic approach could be based on considering these circumstances as risks for any particular group of a poor (health) outcome. The impact of any factor on people depends on the resources available to them to cope with the event or issue

In risk management we look at two factors which operate as multipliers that determine the overall level of risk. The first is the hazard, what is at risk; the second is the probability that the risk will occur.

$$\text{Hazard} \times \text{Probability} = \text{Risk}$$

There may be risk factors for exclusion that create vulnerability these factors may not be primarily to do with income, but we could argue that the lower a persons income (the poorer their “resources” overall), the greater the probability and overall risk the more vulnerable they become to poor health outcomes.

Exclusion becomes a “vicious cycle”. Unemployment is linked to poor health; poor health (particularly mental health), militates engagement in the labour market.

In the same way the greater the number of hazards an individual has the greater the probability and therefore the level of risk.

The groups who are at risk can vary. Some will share a common geography. All the evidence shows that poor people live in poor areas. The APHO recommends¹ using small geographic areas as the larger the area the more diverse the population. He also notes that the most affluent are more likely to be the most adaptable to new health initiatives. The smaller the area SOA or LSOA the less diverse the population and the more likely contact is to be made with those at greatest risk of poor health outcomes. At the same time Marmot advises action across the whole range of social determinants of health.

Given the consensus that links poverty and social exclusion, it is likely that any intervention that increases household income above a certain level will have some impact on health outcomes. Therefore benefit take up schemes may make as great a contribution to improvements as securing employment, some may argue that low pay (on or below the poverty level) may not address exclusion and poverty issues, but actually contribute to it.

There may be gains to self-esteem confidence and well-being and improved social networks from engaging in work. Where there is not paid employment available, volunteering and training where the candidate experiences success may have an impact on well-being, esteem and confidence. This will be significant for those who do not seek engagement with the labour market due to being retired or with long term conditions which make it unlikely that they could secure employment in the immediate future.

Definitions of social exclusion and poverty

Peter Townsend 1979 argued that poverty should not just be viewed in terms of subsistence but also in terms of people’s ability to participate in the customary life of society. He referred to poverty when “.the resources are so seriously below those commanded by the average individual or family that they are in effect

¹ Technical issues in measuring and monitoring targets to reduce health inequalities – Paul Fryers , technical Advisor APHO

excluded from ordinary living patterns, customs and activities.” Resources do not just refer to cash incomes but also collectively-provided services.

The Social Exclusion Unit (SEU) was established in December 1997. Based in the Cabinet Office, the unit was tasked with providing, “joined up solutions for joined up problems.”

Almost immediately a debate around definition and measurement began. Part of the problem in identifying indicators was there was no agreed definition of what social exclusion was or what caused it. What was clear from the start was the intertwining of social exclusion with poverty as illustrated by the following definitions.

Poverty is pronounced deprivation in well-being, and comprises many dimensions. It includes low incomes and the inability to acquire the basic goods and services necessary for survival with dignity. Poverty also encompasses low levels of health and education, poor access to clean water and sanitation, inadequate physical security, lack of voice, and insufficient capacity and opportunity to better one’s life. —**World Bank**

Fundamentally, poverty is a denial of choices and opportunities, a violation of human dignity. It means lack of basic capacity to participate effectively in society. It means not having enough to feed and clothe a family, not having a school or clinic to go to; not having the land on which to grow one’s food or a job to earn one’s living, not having access to credit. It means insecurity, powerlessness and exclusion of individuals, households and communities. It means susceptibility to violence, and it often implies living in marginal or fragile environments, without access to clean water or sanitation. —**United Nations**

Duffy 1995, “the inability to participate effectively in economic, social political and cultural life, alienation and distance from mainstream society.”

Walker and Walker 1997-8, “.the dynamic process of being shut out ... from any of the social, economic, political and cultural systems which determine the cultural integration of a person in society”

All definitions refer to the problem as multi-faceted. They accept to some degree that it is related to poverty, especially understandings of poverty that go beyond low income and address the multiple dimensions of deprivation.

The New Policy Institute, funded by Joseph Rowntree Foundation in 1998 produced its first annual report monitoring poverty and social exclusion. These reports have two poverty indicators. A household is deemed to be in poverty if its income is less than 60% of median household income for the year in question, also referred to as the poverty line. In 2008-09 the median income, net of income tax and council tax after deducting housing costs (rent or mortgage interest, water charges and buildings insurance) was worth per week

- £119 for a single adult
- £161 for a lone parent with one child under 14
- £206 for a couple with no children
- £288 for a couple with two children under 14.

The second definition was of “deep poverty” (household income at least one third below the poverty line). In 2008/09 a record number of people, 5.8m were in deep poverty.

Each report refers to 46 main indicators² spread across 6 chapters. All the indicators draw on existing routinely collected datasets. Four chapters divide the data areas into

Children – under 16
Young adults - 16 – 24
Adults 25 – “normal retirement age”
Older people

The other two chapters are concerned with Poverty and low income and communities.

Each chapter is subdivided into various themes including, health, education, income and access to services. The report identifies within a given population cohort the factors that indicate poverty and social exclusion and this could be extrapolated to reflect who is vulnerable.

Since then a further 12 annual reports have been published. Monitoring Poverty and Social Exclusion 2010 noted, all indicators of ill-health have improved or stayed steady for the last 10 years.

“Infant mortality rates are down among children born to parents in both manual and non manual social

² See Appendix 1

classes. Premature death rates have fallen for men and women.

The proportion of adults at risk of mental health (sic) is lower than a decade ago. The number of older adults with a limiting long term illness or disability has remained constant. However, there are still significant differences among different groups. ***The risk of mental illness for someone in the poorest fifth of the population is around twice the average for instance*** (my emphasis)

Causes

Any of these definitions suggest reference to a set of indicators rather than single ones and that income or household poverty is a significant factor. The indicators and causal measures of social exclusion vary from commentator to commentator as they are at least in part determined by the view of what causes and “cures are for exclusion. Ruth Levitas³ characterised three views of the problem of poverty and exclusion.

Three different views each with inherent problems have been characterised

1. RED or redistributive discourse. This derives from critical social policy which sees social exclusion as a consequence of poverty. Peter Townsend 1979 argued that poverty should not just be viewed in terms of subsistence but also in terms of people’s ability to participate in the customary life of society. He referred to poverty existing when “... the resources are so seriously below those commanded by the average individual or family that they are in effect excluded from ordinary living patterns, customs and activities.” Resources do not just refer to cash incomes but also collectively-provided services. The crux of his argument was that raising benefit levels to reduce poverty was key to reducing exclusion. Household income being the lead indicator.
2. SID or social integration puts a much greater emphasis on labour market attachment. In which individual’s engagement with paid work is seen as the key to overcoming poverty and exclusion. Those who are workless are then represented as those at greatest risk of poverty and exclusion. This view glosses over the way

³ Defining and Measuring Social Exclusion: A critical Overview of Current Proposals, Radical Statistics

poorly paid jobs which include long or asocial working hours could contribute to exclusion and poverty. While a lead indicator for RED is low income for SID it is economic inactivity.

3. MUD or moral underclass discourse this emphasises the moral and cultural causes of poverty which is centrally concerned with the moral hazard of dependency and thus concerned with workless households rather than individual labour market attachments. MUD focuses on the consequences of exclusion for social order and particular groups such as unemployed and potentially criminal young men, lone parents and never married mothers.

Measurement

All agree however that as the problem is multi-faceted poverty and social exclusion require multiple indicators. When considering what those indicators should be pragmatic considerations have had a considerable impact in the decision about which indicators should be included. A general consensus emerged that rather than moving from defining to data collection, the process would need to be reversed in that a main requirement was for data that already existed and in a reliable format.

Priority

One of the issues we have is an area with such high levels of need, how do we decide what our priorities are. As funding becomes tighter the issue becomes much more pressing. Our Healthier Nation⁴ observed, "If everything is to be a priority then nothing will be a priority".

This is further complicated by the lack of agreement over what social exclusion is and its relationship to poverty. Add to this a confusion of causal and effect factors and a political landscape which can determine the definition. Even when there is agreement over some of these issues, the debate then moves on to rage around what are the most effective ways of dealing with the consequences are.

Prioritising has always been as fraught. Acheson published his Independent Inquiry into Inequalities in Health in 1998. He was asked to make recommendations for policies which would reduce health inequalities he made 39 recommendations, in

which increasing benefits to women of child bearing age received the same status as reducing traffic speed.

If the drivers for exclusion and poverty can be identified in various ways (RED, SIP or MUD) then cause cannot be clearly defined. Presumptions are then made about causal relationships between the social processes represented by the indicators, as well as their relative importance. As Ruth Levitas observes, "targeting particular social groups makes it possible to claim "success" in reducing social exclusion without addressing the fundamental issues of poverty and inequality."

Addressing Poverty and Social Exclusion

Hirsch, special adviser to the Joseph Rowntree Foundation argues that if deprivation is concentrated, then we should seek to reduce the concentration of deprivation not just the overall level. This could justify a geographic approach to a small area, it does however assume that the solutions to issues of poverty and exclusion; income whether its benefit levels, worklessness, or poverty caused by low wages exist, in small geographic areas.

However addressing issues around access to appropriate and effective services (see Townsend RED above) could begin to unlock some issues as people in poverty find it hard to participate where they lack the resources to do so. This lays out a challenge not for the target population themselves but for service providers and those charged with addressing the issues.

One aspect which is less readily considered is the issue of social exclusion driven by public and social policy. For example the Homeless Persons Act in the late 1970's gave certain groups within the population a statutory right to housing, mainly families with dependent children, older or infirmed people. Specifically excluded from the legislation were single homeless people, childless couple's and people who were deemed to have become intentionally homeless.

Other Acts with significant exclusions are the Mental Health Act, which excludes from certain rights to services, people with drug and alcohol problems, people with a personality disorder, and people whose condition is deemed not treatable. Often these services are subject to strict access criteria like, FACS, which ration services to as smaller group of people as possible.

⁴ Department of Health 1999.

There are also groups of people who are excluded because a service is not accessible; physically, emotionally or for other reasons.

There are also people who are excluded from services because the service, although accessible does not meet their needs or cope with the presenting behaviour of the person.

A further dimension can lie in discriminatory attitudes or stereotypes which mean that any pressure to provide services can be readily dismissed. For example for a long time it was maintained that older people in Asian communities did not need bespoke services because;

- a) They are all looked after by their families
- b) Why should they have special services – they can use the ones that exist

To address the exclusion arising from these issues lies, not only in changing the behaviour of the target audience and that of service providers. Oppression can be internalised and unconscious stereotyping can lead to discrimination. One of the major ways of challenging this is to give service users a voice and a choice, not just in specially designed meetings, but as integral to the process of services delivery.

Empowering people is about supporting them to think through and make the best possible decision about the outcomes they want to achieve and how they can be achieved with the resources available to them. This means staff developing the skills to work with people through the choice and consequence process. It is not empowering to allow people to believe they have choices that do not exist; neither is it empowering to let people make poorly informed choices without full knowledge of the potential consequences.

Joined up services

Often joined up working is presented as jointly carrying out activities e.g. assessments so that there is a clear pathway through the system. Whilst this focus has merit it is overwhelmingly concerned with **what** is done and **when**, with a strong system focus. On its own this will not deliver significant service change unless we begin to focus on **how** we do something in order to achieve a **joint outcome**. This requires a shift from process and structure to outcome and culture. We should be clear that we mean culture which is the sum total of the values at work in a service and should include the policy areas from Marmot.

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of health prevention.

World Bank model of Sustainable Development

The World Bank Model has a model of sustainable development it identifies and describes four dimensions of sustainable development. If one of the dimensions is low it will negatively impact on the others. The model proposes that building factories or offices and new houses alone will not regenerate an area.

Regeneration involves building social capital and human capital along with successfully exploiting environmental assets and economic growth. This model was used by Sheffield Hallam in their work with the South Yorkshire Coalfields HAZ in the mid to late 1990s.

If these four dimensions can act to grow or diminish another, then it could be argued that an areas general “health” or potential for growth in prosperity could be measured by looking at indicators of relative strength in each of these areas and investing in its growth or development. Thus the most holistic or “joined up” working is not merely where agencies work hand in hand but where the possible impact of an outcome is as broad as possible across the following.

1. Human capital.

This is the sum total of individual’s skills and health. It enables people to participate. In Stoke, we have poor skills and high levels of long-term limiting health problems.

2. Social capital

This is about the levels of trust, reciprocity and engagement within and between communities. Low social capital leads to impoverished networks and connectivity outside of our immediate communities. Lack of trust not only affects social life, but also the willingness to engage with other groups of people, or a heightened fear of crime and “strangers”.

3. Environmental assets

Not only includes natural assets like mineral wealth and topography but also the quality of the built environment. It includes how an area looks. Our perceptions about the safety of an area can be strongly influenced by its appearance.

4. Economic assets

Wealth creation, capital investment, generating jobs, growing businesses and encouraging entrepreneurial activity and the infrastructure that relates to it are the key components of economic regeneration.

The analysis against these criteria is recognisable in the **Experian Model of Resilience**⁵ which looks at

People
Business
Place
Community

Prof Suzanne Fitzpatrick constructs a similar model in her work which harmonises theories on the causes of homelessness by looking at

Economic drivers – low income, unemployment, debt defaulting on loans

Housing – limited supply, lack of affordable housing, overcrowding, unfit conditions, illegal practice by landlords

Interpersonal – limited or disruptive family or social network, victim of violence, perpetrator of crime

Individual – physical/mental/sexual health issues, learning disability, physical sensory disability, age, poor educational attainment.

Brighter Futures’ role in tackling social exclusion

The services we provide and how we provide them are based upon this understanding of poverty and exclusion. We support people to become more independent and have control in their lives. That people are empowered and have control is one of Marmot’s key policy areas.

Our customers get help to agree a personalised plan that identifies the things in their lives that they want to change. Our support empowers people to consider and make choices rather than act on emotion. We believe

⁵ “Understanding resilience. Background Information – West Midlands, September 2010” – Experian Ltd 2010

that given good information in the right way and time and support to think things through most people will make better decisions.

These plans have a strong focus on emotional and mental well-being, we believe that poor mental health, anxiety and stress are important drivers of poorer physical health outcomes.

In our experience people are more likely to address health issues like diet, smoking and lack of exercise when mental and emotional well-being is improved.

We provide over 200 units of affordable accommodation for rent, all of which are fully furnished and equipped to exceptionally high standards. We believe that without a good environment where people feel safe they are less likely to address other issues in their lives.

We recognised that purposeful activity, whether its employment, training or engaging with the community and building social networks improves self esteem, a sense of belonging and purpose to life.

We facilitate and host transitional employment placements and volunteering opportunities. We operate work clubs which allow people to gain the skills and knowledge they need to return to education or employment. We use social enterprise as a route to developing employment opportunities

We seek to make a difference that is sustainable; we measure our performance against the following outcomes:

- people become healthy and fulfilled
- people feel part of a community
- people value their environment
- people work and become independent

Our services are developed and operated in collaboration and participation of our customers and the involvement of commissioners

We are committed to adding value to the local economy not only by using local money to provide services to local people, but by targeting employment, training and procurement locally. We are proud that many of our customers have gone on to become staff at Brighter Futures.

Gill Brown

April 2011

APPENDIX ONE

Rowntree/ New Policy Institute Key Indicators of Poverty and Social Exclusion

Income	Adults
Gap between low and median income	Individuals wanting paid work
Individuals with below 50% of average income	Households without work for 2 years or more
Individuals with below 40% of average income	On low rates of pay
Long-term recipients of benefits	Insecure in employment
Individuals with spells of low income	Without access to training
Self-reported difficulty managing financially	Premature death
	Limiting long-standing illness or disability
Children	Depression
Children living in workless households	
Children living in households with below 50% average income	Older People
Low birth weight babies	Pensioners with no private income
Accidental deaths	Spending on essentials
Pupils gaining no GCSE grade C or above	Limiting long-standing illness or disability
Permanently excluded from school	Anxiety
Children whose parents divorce	Help from social services to live at home
Births to girls conceiving under age 16	Without a telephone
Children in young offenders' institutions	
Young Adults	Communities
Unemployed	Polarisation of work
On low rates of pay	Spending on travel of poorest, relative to middle income
On severe hardship payments	Lacking a bank or building society account
Starting drug treatment	Non-participation in civic organisations
Suicide	Dissatisfaction with local area
Without basic qualification (at 19)	Vulnerability to crime
With a criminal record (at 23)	Homes lacking central heating
	Households in temporary accommodation
	Overcrowding
	Mortgage arrears

Other areas have been rejected as they have not identified a source of reliable data, these include debt, movements on and off benefits, nutrition, outcomes for children in care, homelessness in young adults, adequacy of pensions, inequalities in service provision, isolation, people in institutions, age specific hospital waiting times, crime in small geographic area, damp/unfit housing etc.