

Becoming socially included

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Abstract: Professor Peter Huxley has made a considerable contribution to Social and Community Psychiatry. In this paper, I reflect on some aspects of social psychiatry including its importance, scope and current status, as well as contemporary thinking on the social exclusion and employment of people with mental health conditions. Central to much of the thinking in these areas are health inequalities, the social determinants of ill-health and the bidirectional relationship between social factors and mental ill-health. I leave the final words to Peter Huxley: “Psychiatry and social science both work to understand and address the consequences of social adversity and injustice, even if psychiatry is sometimes reluctant to acknowledge this”.

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Introduction

I first came across Peter Huxley in 1982 when I was training in psychiatry in London and was about to start my PhD. This introduction was not in person but through the book he co-authored with David Goldberg, *Mental Illness in the Community. The Pathway to Psychiatric Care* (Goldberg and Huxley, 1983). This had a considerable influence on my subsequent PhD work and my trajectory into community and social psychiatry. The book put me in my place, providing a

context for the work of secondary mental health services which I began to see as a service for a remote and filtered group of ‘mentally-ill’ people. Mental ill-health was clearly something that existed across the population, in the community and in general medical practice. Our psychiatric understanding of mental disorder was “...effectively defined by the characteristics of the referral pathway to the psychiatrist’s office” (Goldberg and Huxley, 1983, p.1). So began my interest in epidemiology and social psychiatry.

Almost 20 years later I was asked by the Royal College of Psychiatrists to lead on the development of a report on vocational rehabilitation for people with mental health conditions (Royal College of Psychiatrists, 2002). By that time Peter had been involved with the first systematic review of vocational rehabilitation for the Cochrane database (Crowther et al., 2001a, 2001b) and was asked to be a member of the Working Group that I chaired. The systematic review showed the effectiveness of supported employment, particularly Individual Placement and Support (IPS), as a means of supporting people with psychoses into open employment. It revealed a means of facilitating the participation of a group of people, traditionally thought to be unemployable, in the open labour market. This focus on employment and the possibility of supporting people with enduring mental health conditions into employment, led me to broaden my outlook and to examine the social exclusion of people with mental health conditions.

The Royal College of Psychiatrists never published an update of *Employment opportunities and psychiatric disability*, instead I was asked to expand the report into all areas of social exclusion. This resulted in the publication of a book *Social Inclusion and Mental Health* and its subsequent second edition (Boardman et al., 2010, 2022). By that time Peter had published on Social Inclusion and had commenced work on the development of a Social Inclusion Index, the Social and Community Opportunities Profile (SCOPE) (Huxley and Thornicroft, 2003; Huxley et al., 2012).

Peter Huxley’s influence on social psychiatry can be seen throughout his body of work, including his two books with David Goldberg and his contribution to reducing stigma, access to social capital, social networks, urban regeneration, and quality of life. Through this work Peter has made a considerable contribution to Social and Community Psychiatry, including the examination of social factors influencing mental health and ill-health, as well as with individual and social outcomes. Importantly, he has brought a social care perspective into mental health settings.

In this chapter, I will pay tribute to Peter by briefly reflecting on social psychiatry, the social exclusion of people with mental health conditions and, finally, employment and mental health. All topics that reflect an overlap in our work and interests.

Social psychiatry

There is always something about studying human mental life and behaviour that has the feeling of the 'silo' about it. Academic disciplines and the related professional practices tend to work in isolation and psychiatry is no different. Social psychiatry and the broader study of social medicine both have their starting points in the study of disease and the medical gaze. Nevertheless, the approach of social psychiatry broadens our view of what we have traditionally considered to be 'mental illness' away from the individual to encompass the social environment and its effects on mental health as well as the reciprocal effects of the person with mental ill-health on their environment (Henderson, 1988; Leff, 2010). The scope of social psychiatry includes the impact of social structures and experiences on the onset, course and outcome of mental disorders; the development and evaluation of social interventions and systems of service delivery; and the influence of society on the construction of, and responses to, mental disorder (Wing, 1980; 1991; Morgan and Bhugra, 2010).

Whilst we cannot ignore the importance of neuroscience and biology in helping us understand mental health and ill-health, we may be justified as seeing psychiatry and the study of mental ill-health as '*essentially social*' (Bebbington, 2010). Just as individuals are embedded in the social environment, being shaped by it and in turn shaping it, so mental health conditions are influenced by this environment and shape the social and cultural responses. In this way, the social components of mental health conditions appear incontrovertible.

Whilst we are aware that mental health is frequently in the news, we have a considerable way to go in reducing stigma, obtaining greater parity in healthcare funding, improving integration across social and health sectors and providing more equitable funding across the biological and social research studies of mental ill-health (Priebe et al., 2013; Royal College of Psychiatrists, 2013). It is clear that systematic studies of epidemiology have revealed many social and environmental factors that play a significant role in the genesis of mental disorders (Uher and Zwicker, 2017). Nevertheless, these factors, including early adversity, often predict a range of mental health outcomes, and we still do a poor job in predicting who will and who will not develop a disorder (Davey-Smith, 2011; Uher and Zwicker, 2017).

Despite these advances, it may not be unreasonable to ponder whether social psychiatry has any future. After all, the brain sciences are in their ascendancy. We do need an interdisciplinary approach that provides an intellectual environment to allow the relevant conceptual work to be carried out, one that links the individual with the social world. The sociological literature has many useful constructs, such as the 'sociological imagination', 'Habitus'

or ‘embodied social structures’ that may be helpful and offer a means of linking hierarchical social structures to our social identity and understanding the relationships between social stratification and health (Bourdieu, 1989; Wright Mills, 2000; Hatch and Mach, 2010). As Rose (2016) suggests, we need to ask, “how does adversity get under the skin?”. The term ‘social suffering’ has been used to characterise the effects of injurious social forces on the human experience (Kleinman et al., 1997; Wilkinson, 2005). Mental health conditions are a form of social suffering, and this links them to many other human problems and experiences, such as “...*broken relationships, lost opportunities, social failures and hostility, of stigma, of grinding poverty and social isolation*” (Morgan and Kleinman, 2010, p.52). It brings into the picture other actors (family, friends, neighbours), it has personal meaning, it is both subjective and collective, but it “...*is not experienced as a discrete problem starting outside the flow of everyday life, it is part of an entangled set of circumstances*” (Morgan and Kleinman, 2010, p.52).

Would seeing public mental health as a central component of social psychiatry help it progress? Social psychiatry can be seen as a part of social medicine (Jablensky, 1990; Wing, 1991) linked to the area of public health, thereby moving us away from a focus on the health of the individual to that of the population; the effects of the environment on population health and the importance of grand public schemes to improve the physical environment as a means of combating disease. These approaches remain as important today as ever as we struggle against the threats of climate change and the consequences of social inequalities that continue to determine levels of morbidity and mortality (Marmot et al., 2021). The burden of disease in lower-income countries continues to be dominated by infectious disease, but mental disorders also contribute significantly to the global burden of disease and will continue to do so in the aftermath of the COVID-19 pandemic (Desjarlais et al., 1995; Jablensky, 1999; Whiteford et al., 2015; Campion et al., 2020).

A public health approach would be expected to address the prevention of mental disorders and to promote well-being (Campion, 2019) and could be directed at primary, secondary and tertiary levels. Examples include prevention of mental disorders and suicide, reducing mental health inequalities, and the governance and organization of mental health service provision. Whilst we accept that prevention should be concerned with preventing the health condition or associated impairments arising in the first place, it is also important to stop the health condition from leading to further social and economic disadvantage. A public health approach to reducing health inequalities would entail taking action to reverse the fundamental causes, preventing the harmful environmental influences, and mitigating the negative impact on individuals.

Social exclusion

We are aware that health outcomes, such as life expectancy, are not distributed equitably across populations (Marmot, 2015). Health status is correlated with a person's place in the social hierarchy and, overall, it improves as we ascend the ladder of privilege and prosperity. This applies to physical health and mental health conditions. These health inequalities are 'systematic, avoidable and unfair.' (McCartney et al., 2019; p.31).

This link between social inequalities and mental health conditions has been known since the 19th century when it was observed that the overrepresentation of the 'pauper classes' in asylums for the insane pointed to a relationship between income, status, and insanity (Jarvis, 1971; Dohrenwend, 1990). Repeatedly, studies have demonstrated an inverse association between socio-economic status and the prevalence of mental health conditions including schizophrenia, depression, antisocial personality disorder, alcohol and drug abuse, suicide and suicidal behaviour and general measures of psychological distress, (Faris and Dunham, 1939; Allen et al., 2014; Platt et al., 2017). Not only do we find that inequalities are associated with the prevalence of mental ill-health, the most disadvantaged also tend to have reduced access to mental health and social services and when they do access help, the quality of their experiences and outcomes are often poorer (Centre for Mental Health, 2020a, 2020b; Delgado et al., 2016).

The consistent finding of these social inequalities in mental health prompt us to look at other aspects of inequity that relate to people with mental health conditions. The WHO regards people these groups of people as "...among the most marginalized and vulnerable groups. They often are excluded from mainstream social and economic activities, as well as from decision-making on issues that affect them. Their human rights are violated frequently, and they are not provided with educational and vocational opportunities to meet their full potential" (World Health Organisation, 2010, p.vii). This concept of social exclusion has been observed by many commentators and has been captured in a concise definition by Burchardt et al., (2002) as: "An individual is socially excluded if he or she does not participate in key activities of the society in which he or she lives" (p. 30).

A convenient way of analyzing the lack of participation experienced by people with mental health conditions may be carried out with reference to five general domains (Burchardt et al., 2002b; Boardman et al., 2022):

- *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)
- *Health and health service engagement* (exclusion from health and health services) – having good health and accessing appropriate services.

The book that emerged from the Royal College of Psychiatrists scoping group on Social Inclusion and Mental Health examined the exclusion experienced by people with mental health conditions in these five areas and found strong evidence of exclusion in all five domains (Boardman et al., 2010, 2022). Recent work by Peter Huxley using the SCOPE concludes that people with mental health conditions are more socially excluded when compared to the general population (Huxley et al., 2016; Carvalho dos Santos et al., 2018). Supporting this conclusion, a systematic review of 22 observational studies that examined social exclusion covering four areas of economic, social, political, and cultural exclusion, found an association between high social exclusion or low social inclusion and mental and general ill-health (van Bergen et al., 2018).

Many commentators concur with the WHO's view quoted above that people with mental health conditions are among the most socially excluded of all groups, but this may require some qualification. Social exclusion can be seen as a multidimensional and dynamic process driven by unequal power relationships operating at different levels from the individual and group and to the national and international. This view sees exclusion and inclusion as a continuum along which people and groups have varying degrees of participation and unequal access to resources and rights and implies that people may be excluded to some degree or another across the five domains. This appears to be the case for people with mental health conditions, although some groups of people with these conditions are likely to be excluded to a greater degree than others. Factors that seem to determine this are the severity and duration of their conditions, any comorbidity, associated demographic and social identity characteristics, features of the physical and social environment, the extent of adversity experienced in their early life and in their subsequent life course. People with long-term and severe conditions such as psychoses and those with associated intellectual or physical disability or neurodevelopmental conditions may experience greater exclusion than other groups. Combinations of multiple difficulties of mental ill-health, substance misuse, physical disorders, homelessness, involvement in prison or other aspects of the criminal justice system, may result in 'severe and multiple disadvantage' or 'deep social exclusion', combinations that may considerably shorten their lives (Fitpatrick et al., 2013; Bramley et al., 2015; Aldridge et al.,

2018). These multiple difficulties are not randomly associated but are linked through a background of poverty, social marginalisation, adverse childhood experiences, poor education and job prospects, untoward life events that determine varied life trajectories and pathways into exclusion (Bramley et al., 2015). The causal pathways of the health outcomes related to this exclusion may not be different from those of the causes of health inequalities generally, but they are different in degree (Marmot, 2018), and the pathways and intersection of relevant factors are complex, making the design of relevant interventions challenging (Luchenski et al., 2018).

From examining the associations between mental health conditions and indicators of social exclusion it becomes clear that mental health conditions are a significant risk factor for poor economic, health and social outcomes. However, the direction of causality is often difficult to establish, the causal pathways can operate in both directions such that mental health conditions can be both a cause and consequence of exclusion.

At an individual level it is also clear that aspects of all five domains of social exclusion are important for the quality of life of people with mental health conditions and this is supported by many of the first-person accounts quoted in a range of publications. Studies examining what people with severe mental health conditions consider to be important to their quality of life or how their quality of life has been affected by their mental health have revealed six major themes: well-being and ill-being; control, autonomy, and choice; self-perception; belonging; activity; and hope and hopelessness (Connell et al., 2012). These six themes are almost identical to those seen in the studies of what people with mental health conditions consider to be important for their recovery (Connectedness, Hope and optimism, Identity; Meaning in life; and Empowerment i.e. CHIME - Leamy et al., 2011), but contain an additional theme, that of well-being and ill-being. Within this theme, well-being was not just the absence of being ill but contained the experiences of an overall sense of well-being; feeling healthy, peaceful, calm and relaxed, safe and free from worry and demands (Connell et al., 2012). The notion of well-being is an important aspect of quality of life for everyone, including those with severe mental health conditions, and an important consideration for population health.

Employment

The study of work and worklessness has clear relevance for social psychiatry. Work may be seen to have a uniquely human quality, essential not only for our

material subsistence, growing needs and the wealth of nations, but also for our psychological needs and sociability. Work is fundamentally relational and assists in defining who we are and our relation to others. But also, the nature of work and its availability is subject to wider political, economic, and social forces. Importantly, work and the lack of it, has a significant effect on our health. In addition, people with mental health conditions, particularly long-term conditions, are disadvantaged in the labour market.

Unemployment and health

The loss of income and the subsequent financial insecurity and reduction in standards of living are, of course, important consequences of unemployment, but its effects are more wide ranging, including stigma and loss of status that saps self-esteem. One impact of joblessness on the individual is the loss of freedom of decision, marking as a central deprivation (Sen, 2000). Associated with this is a loss of participation, not only in economic opportunities, but also in the life of the community resulting in reduction of social networks and social engagement. It is, therefore, hardly surprising that unemployment, particularly when prolonged, has a significant impact on mental and physical health. Unemployment is associated with an increase in rates of overall mortality, cardiovascular disease, limiting long-term illness, higher use of medical services and medication (Bartley, 1994; Jin et al., 1995; Voss et al., 2004).

Many studies report strong associations between joblessness and poor mental health or well-being (Warr, 1987; Dooley et al., 1994; Fryers et al., 2003), revealing higher rates of anxiety and depression, alcohol and substance use and alcohol related death among the unemployed than among those in work, even after taking account of age and sex (Norstrom and Ramstedt, 2005; Eliason and Storrie, 2009). Whilst it is often uncertain as to the causal relationship between mental health and unemployment, it is likely that the causality operates in both directions – unemployment is a cause of poor mental health and poor mental health can result in job loss and difficulties in re-entering the workforce. Longitudinal and cohort studies that examine the transitions between employment and unemployment (and vice-versa) support a direct causal link between job loss and mental ill-health. These effects can be seen in studies that examine the effects of workplace closure or radical restructuring of the workforce (Andreeva et al., 2015) and in longitudinal studies that examine the transitions from employment to unemployment and vice-versa. These latter studies generally show a decline in mental well-being after job loss and an improvement in mental health and quality of life following a move from unemployment back to work (Joelson and Whalquist, 1987; Weich and Lewis, 1998; Winkelmann and Winkelmann,

1998; Montgomery et al., 1999; Flint et al., 2013). In addition, they suggest that the nature of the employment may also affect well-being: a move from unemployment to stable employment can result in a larger increase in mental well-being than a move to insecure employment (Strandh, 2000).

Job quality and precarious employment

For the individual, work is a valuable asset. It provides an income to support our material needs, but it also has symbolic significance, contributing to our status, sense of identity, pride, worth and other aspects of our well-being. It facilitates our social networks and sources of support. Its lack, as in states of unemployment, are detrimental to our health and well-being, reinforcing our belief about the value of employment. Nevertheless, there is another side to the contribution of employment to our health as not all working situations are good for our physical and mental health.

We are familiar with the fact that the working environment can be physically hazardous and may expose workers to a range of noxious agents, but it may expose people to a range of psychosocial hazards that put workers at risk of poor health. Jobs can be poorly paid or provide people with insufficient or overly long working hours. They may be temporary or insecure or place people at risk of job loss or redundancy. They may provide exposure to conditions of low psychosocial quality that affect the mental health of workers. Whilst such poor conditions are common in low-income countries, they have become increasingly common in high income countries.

Workplace factors reflecting low psychosocial quality include high job demands, low job control, high effort-reward-imbalance, low relational justice, low procedural justice, role stress, bullying and low social support, all of which are associated with an increased risk of developing common mental health conditions. (Butterworth et al., 2011; Harvey et al., 2018). Other work-related factors, such as organisational change, job insecurity, temporary employment status and atypical working hours, are also likely to be significant risk factors. Moving from unemployment to employment with poor psychosocial quality may be as bad, or worse, for health as moving into unemployment (Butterworth et al., 2011). Bullying and discriminatory practices are a major source of workplace stress and mental disorder and people with existing mental health problems may be at special risk of harassment and bullying (Rudkjoebing et al., 2020). In 2016/17 36% of employees in the UK reported being in low quality work and this group were more likely to experience poor health than those in better quality jobs. People tend to remain in these poor-quality jobs – half of those in poor-quality jobs in 2010/11 remained in poor-quality work in 2016/17 (Tinson, 2020).

It is not only the psychosocial quality of the working environment that contributes to poor mental health, but also the structure of employment which can affect job quality. Recently, in high income countries, there has been a movement away from the standard employment model in which workers earn wages or salaries in a dependent employment relationship with their employers, jobs that usually offer a stable contract and employment as well as labour law and social security protection ([International Labour Organisation, 2015](#)). Instead, there is much greater labour market flexibility with a weakening of regulations and protective policies. The result is an increase in forms of insecure or ‘precarious’ employment ([Benach et al., 2014](#)) including “zero hours contracts” and “gig economy work”, and a reduction of labour and social protection leaving the employee to make their own arrangement for pensions.

These insecure forms of employment and working poverty are common in low- and middle-income economies where around 80% in low-income countries and just over 50% in middle-income countries work in informal employment and more than 1 in 4 workers live in extreme or moderate poverty ([International Labour Organisation, 2015, 2019](#)). Whilst increasing in number, these jobs are much less common in high income countries with around 10% of people being in temporary work or without an employment contract ([International Labour Organisation, 2015](#)). In the UK in 2018, almost 4 million workers were estimated to be in insecure forms of employment – 12% of the workforce ([TUC, 2018](#)). In the UK, there has also been an increase in “underemployment” (employed persons who have not attained their full employment level), and a rise of ‘in work poverty’ (working households with incomes below the poverty line) ([International Labour Organisation, 2015](#); [Joseph Rowntree Foundation, 2017](#); [Tinson, 2020](#)). Around 1 in 3 adults who are in paid work in the UK are in poverty or in insecure or poor-quality employment ([Bailey, 2016](#)).

Whilst flexible employment may work for some, for most it tends to erode working conditions with a detrimental effect on psychological well-being and physical health ([De Witte et al., 2016](#)), as does living below the poverty line ([Joseph Rowntree Foundation, 2017](#)). A systematic review of 29 studies ([Virtanen et al., 2005](#)) showed an almost two-fold higher risk of psychological distress and poor physical health among temporary workers, the risk being stronger for those in the least stable jobs and greater where the unemployment rate was low – indicating that a sense of comparative insecurity matters in this as in other psychosocial risks.

Poor-quality working environments and precarious and insecure employment are all likely to have effects on population health and already existing health inequalities (Marmot Review Team, 2010; [Public Health England, 2015](#)). They both reflect and reinforce the social gradient of health and can have knock-on

effects for future generations. The potential magnitude of these effects is brought home to us when we consider that our working lives represent the single longest period of the human lifespan, amounting to some 40-50 years. This is the greater part of our adult lives, a time when many are raising families with the consequent responsibilities of dependents and effects on subsequent generations (Marmot Review Team, 2010).

Mental health conditions and the workforce

Overall, people with mental health conditions have lower rates of employment than the general population. In addition, they have a lower re-entry rate into the labour market, particularly in economic downturns (Farre et al., 2018). Because of these lower employment rates people with mental health conditions earn, on average, significantly less than those without these conditions. Across OECD countries the employment rate of people with a mental disorder is between 55-70%, 10-15% lower than for people without a mental disorder (OECD, 2014). However, these rates of employment vary across diagnostic groups and with severity of the disorder (Luciano and Meara, 2014; Bond and D'Arcy, 2020). People diagnosed with schizophrenia and other psychotic disorders are even less likely to be employed than are people with physical disabilities with only 10-20% in the UK in some form of employment, although the rates of those in open employment is lower and may vary considerably across European centres (Marwaha and Johnson, 2004; Marwaha et al., 2007). Open employment rates in people with bipolar affective disorders may be higher, between 40-60% (Marwaha et al., 2013), but is associated with underperformance in the workplace and a decline in occupational status over time, often related to continuing depressive symptoms and cognitive deficits (Gilbert et al., 2013). The 2014 Adult Psychiatric Morbidity Survey in England (McManus et al., 2016) reported that almost a third of those with common mental health conditions were unemployed and a further 33% were economically inactive. Those that make it into work are more likely than others in the general population to be in part-time and temporary employment and have more than double the risk of losing their jobs. They represent the highest number of those claiming sickness and disability benefits (DWP, 2016; McManus et al., 2016).

Vocational rehabilitation and mental health conditions.

Historically, work has played a role in the management of people with mental illness, in the asylums (Ernst, 2016). Its role and importance in rehabilitation

practice emerged in the twentieth century alongside the development of Industrial Therapy workshops and the creative therapies (Ernst, 2016). By 1968, in Britain most mental hospitals had industrial therapy units (ITUs) providing contract-based work to industry alongside making their own products and supplying some of the needs of the hospital. As the asylums closed the hospital workshops relocated to the community, it became obvious that few people from these settings went on to get paid 'open' employment in the labour market, thus bringing into question the traditional 'train and place' model of occupational rehabilitation in use at the time.

One response to this failure of traditional vocational rehabilitation was the development during the 1980s in the USA of new forms of supported employment for people with longer-term mental health conditions. The Choose Get Keep model of rehabilitation (Wing and Brown, 1970) began the shift from viewing work solely as a form of therapy to one that viewed it as a personal goal of the patient in which the practitioner's role was to facilitate rehabilitation: choosing, getting, and keeping was what the individual did to attain their goals.

In 1993, Becker and Drake published the first manual of the Individual Placement and Support (IPS) approach to vocational rehabilitation (Stein and Test, 1980). The IPS approach is a form of supported employment and differed from previous approaches to vocational rehabilitation. The IPS model adopted a 'place and train' approach, in which the primary goal of the was to directly find a job and then provide continued support. Its approach was fundamentally 'person-centred'. In 1996, the first Randomised Controlled Trial (RCT) of the IPS approach was published showing that people with longer-term mental health problems could be directly supported to gain and retain open employment without the use of pre-vocational training (Danley and Anthony, 1987). By 2001, Peter Huxley's Cochrane systematic review of vocational rehabilitation for people with severe mental illness found that supported employment was significantly more effective than pre-vocational training (Becker and Drake, 1993) and there are now at least 27 randomised controlled trials supporting the efficacy of IPS compared to standard vocational rehabilitation (Drake et al., 1996). Despite this considerable progress, IPS has been difficult to implement internationally, partly because of differences in the labour market (including unemployment rates), differences in regulations on job security and welfare benefits and reluctance of some employers (and mental health professionals) to support these schemes (Boardman and Rinaldi, 2013). As a consequence, IPS schemes have developed patchily and, like many vocational and other rehabilitation services subject to the vicissitudes of funding, trends of closure and economic cycles (Warner, 2013). They are also dependent on the provision of adequate social security and employment safety nets.

Discussion

This brief account of contemporary work on social exclusion, employment and mental health brings out the importance of many social and material factors operating on individuals over the life-course that have a bidirectional relationship with mental health conditions. It also points to factors that are crucial in the determination of physical and mental health inequalities – the distribution of biological, psychological, social, cultural, and material goods or assets in the population. The health and longevity of a population is determined by the strength of these asset flows (Marmot, 2015; Scambler, 2018).

Whether we consider macro- or micro-social phenomena, we cannot ignore the importance of social factors in enhancing the understanding of the causes and consequences of mental ill-health. Over the past 50 years we have witnessed considerable changes in UK society that have had a fundamental effect on the nation's mental and physical health, including the increases in social, income and wealth inequalities, and rates of poverty, a shift away from the post-war consensus and the welfare state, increases in employment precarity, loss of work protection, a fracturing of society and, more recently, a prolonged period of austerity (Atkinson, 2015; Scambler, 2018; Garrard, 2022). These changes, associated with neoliberalism and the transition to financial capitalism, have been associated with the perpetuation of inequalities and social exclusion of disabled groups, which include people with mental health conditions, along with the erosion of the social safety net (Boardman, 2020). Poverty and mental illness have always been closely associated, and people with mental health conditions face the double jeopardy of the stigma of mental illness and that of poverty, both of which are associated with personal shame (Boardman et al., 2022). Alongside this, their behaviour is not only seen as outside the normative bounds of society, but they are also held responsible for their conditions. Scambler (2018) views this as “heaping blame on shame”. This combination of stigma and deviance places many with mental health conditions not only as ‘rejects’ but as ‘abjects’.

This reformulation of the stigmatisation of people with mental ill-health as not only a shameful but as blameful in the eyes of neoliberalism reinforces the importance of retaining and strengthening the relationships between psychiatry and the social sciences. I will leave the last words to Peter Huxley: “Psychiatry and social science both work to understand and address the consequences of social adversity and injustice, even if psychiatry is sometimes reluctant to acknowledge this” (Huxley and Poole, 2023).

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