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Use policy

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Kate Mattheys

Abstract

Since 2010, successive UK governments have pursued policies of austerity that have been characterised by public spending and welfare cuts. There has been little research about the effects of these policies on mental health inequalities, in particular at the local level. This thesis addresses the gap in knowledge with a case study of Stockton-on-Tees, a local authority in the North East of England with high spatial and socioeconomic inequalities. A mixed methods approach has combined: a cross-sectional survey of inequalities in mental health and mental wellbeing between people from the most and least deprived areas; qualitative interviews with people experiencing mental health problems; and interviews with key stakeholders. This project is the first to include a quantitative exploration of local mental health inequalities and their determinants during the current period of austerity. The findings offer key insight into how the social conditions that people live in shape their mental health, and how austerity measures are having a damaging impact on the social landscape locally. The survey identifies a significant gap in mental health and well-being, with material and psychosocial factors underpinning this gap. The qualitative interviews then show how this gap is mirrored in the narratives and experiences of people from these contrasting neighbourhoods. Austerity measures are exacerbating inequalities in mental health by disproportionately impacting on those on the lowest incomes and in the most deprived areas, leading to increasing financial hardship and chronic stress. Services are being challenged with increasing demand, alongside fewer resources to deal with that rise in demand. The findings are discussed in relation to the continuing programme of cuts to social security and public spending in the UK, including avenues for further research and key recommendations for policy makers.

Divided Lives: A local case study exploring austerity and inequalities in mental health

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List of Abbreviations

CAB	Citizens Advice Bureau
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
DHP	Discretionary Housing Payment
ESA	Employment and Support Allowance
EU	European Union
IAPT	Improving Access to Psychological Therapies
IMD	Indices of Multiple Deprivation
JSA	Job Seekers Allowance
LGBT	Lesbian Gay Bisexual Transgender
LSOA	Lower Super Output Area
NHS	National Health Service
PIP	Personal Independence Payment
SF8 MCS	Short Form 8 Mental Component Score
UK	United Kingdom
WCA	Work Capability Assessment
WHO	World Health Organisation
WEMWBS	Warwick Edinburgh Mental Well-Being Scale

Declaration

I declare that this is my own work and has not been submitted for the award of a higher degree anywhere else.

Statement of Copyright

Acknowledgements

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Chapter 1 Introduction

Back in 2010 when George Osborne was announcing his first emergency budget, I was employed as a social worker in a local authority adult social care team. In frontline service the impact of the announced cuts in public spending very quickly became clear, as the local authority was faced with the challenge of making significant (and seemingly insurmountable) cuts in the budget for social care. Over time the language of efficiency savings became commonplace in reports from senior management, and we were tasked to 'think creatively' about support, the need to tap into some elusive "Big Society" ideal of services that would cost little to the public purse. The direct consequence of cuts in spending was that some people began to see reductions in the level of support that they received, and increased costs for the care they did receive. Alongside this, the government's planned cuts to social security, in the guise of so-called welfare reform, began to take effect. People began to lose income and benefits, and were increasingly being forced to attend medical assessments to 'prove' they were unable to work. Academics, mental health organisations, and some sectors of the media voiced concerns around the mental health harms of the austerity programme: the damage caused by the Work Capability Assessment; increasing financial hardship; people ending their lives as a result of being sanctioned.

I decided to undertake this research project because I wanted to explore how people's mental health and wellbeing were being affected by austerity, to research how this significant (and, I argue, ideologically driven) programme of cuts was impacting on people, on their mental health, and on the services that support them. Coming from a sociology/social work background I had an interest in social inequality and its relationship with mental health. I wanted to further explore this relationship, and how austerity measures were impacting on these inequalities at a local level. From a personal standpoint I believe that social research should look towards promoting social justice, and that research cannot be undertaken within

a political vacuum.   As Becker (1967) argues, we need to decide whose side we are on. I wanted to highlight the narratives of the people and services that were being affected by this large scale programme of cuts, casting a light on how austerity was impacting on the lives and experiences of people in one place in the North-East of England.   I believe, as with Freire (1970: 19), that the researcher should follow an approach in which s/he '*is not afraid to confront, to listen, to see the world unveiled…This person does not consider himself or herself the proprietor of history or of all people… but he or she does commit himself or herself, within history, to fight at their side.*'   By listening to, and giving voice to, the experiences of the people and services that were being affected by austerity, I was taking a political side.

The austerity measures that were initiated from 2010 onward were a consequence of the collapse of the global financial markets in 2007. This led in 2008 to the US and European governments entering into an unprecedented public rescue package for the banking sector, amidst widespread concern that whole national economies would collapse (Gamble, 2009). In Europe, the common response to the ensuing increase in national debt and increased unemployment was to usher in what has been termed a new *politics of austerity* (Kitson et al, 2011).   In 2010, the new UK coalition government followed this trend, responding to the national debt by placing the nation on a path towards permanently lower public spending, lower debt, and market led growth. Key targets were cuts in public services, investment in public infrastructure, and spending on social security (Kitson et al, 2011).   The coalition government's approach focused on reducing public expenditure; this policy has continued under the 2015 elected majority Conservative government, although key targets to balance the budget by 2020 have since September 2016 been abandoned.

The social security bill has been a particular severe target for cuts (Taylor-Gooby, 2012), alongside significant cuts to local government (Lupton, 2015). These so called "reforms" have included reductions in housing and council tax benefit (such as the bedroom tax), more

stringent medical tests for Employment and Support Allowance (ESA), increased conditionality (including an increase in the rates of sanctioning), and the replacement of Disability Living Allowance (DLA) with the new Personal Independence Payments (PIP) (Beatty and Fothergill, 2013). In 2013 Duffy found that 21% of the population were living below the government's official poverty line, and nearly all of the welfare cuts have targeted this group of people (Duffy, 2013). The regressive nature of these cuts has led to reports that the financial situations of those at the lower end of the income spectrum have worsened (Belfield et al, 2015), widening social inequality in a nation that was already very unequal (Dorling, 2015). The rise of austerity policies has been accompanied by powerful narratives which portray the welfare state as encouraging 'welfare dependency'. Such well-worn neoliberal rhetoric problematizes the welfare system and recasts poverty as an individual – as opposed to a structural – problem (Pantazis, 2016).

The effects of austerity are also not distributed evenly, spatially or socially (Bambra and Garthwaite, 2015). Across the UK the local authorities hardest hit by government spending cuts are those in the most socially disadvantaged areas (Pearce, 2013). In the UK there is a well-established north-south economic divide (Kitson et al 2011), and in areas such as the North-East, successive waves of public spending cuts are impacting on spatial inequalities (Hudson, 2013). Health inequalities are intimately linked to social inequalities and so a widening of social inequality, as a result of austerity, may lead to a further exacerbation of social and spatial health inequalities. This includes inequalities in mental health. National level research by Barr et al (2015a), suggests that inequalities in mental health may have widened and there is a need to explore the impact of austerity on inequalities in mental health at a local level.

This thesis is an exploration of what happens to mental health in a time of unprecedented cuts to spending and to welfare; an account of the *human price* of government policy. Although government rhetoric highlighted how we were "all responsible" for fixing the

national debt, I will show how it is those on the lowest incomes and living in the most deprived communities who are paying the highest price and carrying the heaviest burden. I explore the social landscape of one town in the North-East of England, and the inequalities that divide and shape the lives of the people there. I document how people's lived experiences are being shaped by austerity, and how longstanding structural inequalities are being compounded by deeply regressive policies. These are having an incredibly damaging impact on the mental health of the people affected by them, causing a chronic level of stress that has a relentless influence on their everyday lives. For those who were already struggling with issues related to their mental health, these policies are creating additional and unnecessary levels of distress, undermining well-being and leading to emotional harm.

Study Context

This PhD has been based within the '*Local Health Inequalities in an Age of Austerity: The Stockton-on-Tees Study'* (www.dur.ac.uk/health.inequalities/). This is a five year interdisciplinary case study that has attempted to explore key debates around localised health inequalities and evaluate the impact and contribution of austerity driven policies to these inequalities. The political and economic context, of austerity measures implemented since 2010, has shown the importance of exploring how factors at the local level shape inequalities in health. Stockton-on-Tees is a particularly important case because it has such high spatial inequalities. In fact it has the highest health inequalities in England both for men (at a 17.3 year difference in life expectancy at birth) and for women (11.4 year gap in life expectancy) (Public Health England, 2015).

My PhD has been attached to a prospective cohort study examining inequalities in health between the most and least deprived areas of Stockton-on-Tees. Comprehensive data on demographic and social determinants of health has been collected about both individuals

and the households they live in. I have treated the cohort study as a cross-sectional survey, analysing the baseline survey findings only.   Whilst the survey also included physical health outcomes, my PhD has taken a specific focus on mental health, exploring the data relating to the gap in mental health and wellbeing between people from the most and least deprived areas, and what is causing the gap.   Alongside this gap in mental health and well-being, I was also interested in inequalities in the lived experiences of people with mental health problems, and the impact of austerity on services.   I therefore built a case for my PhD that used a range of approaches, in order to explore the issue from different angles.   I adopted a mixed method case study design combining data from the survey, the results of qualitative interviews with people recruited from the survey and the local Citizens Advice Bureau, and further interviews with key stakeholders.

Aims and Research Questions

This PhD draws on insights from geography, public health, sociology, and social work.   It aims to add to the evidence base around what living in a period of austerity means for mental health, and to provide an insight into the determinants of mental health – in a particular place, at a particular time.   This means exploring the gap in general mental health and wellbeing between people from the most and least deprived areas, and how austerity, and inequality, impact on the lived experiences of people who report having mental health problems. Also, I attempt an analysis of the support that is available to people and how services have been affected by cuts, and how they are responding to this challenge.   My research questions are summarised:

1. Are there inequalities in mental health and wellbeing between people from the most and least deprived neighbourhoods of Stockton on Tees, and what factors are contributing to these inequalities?

2. What are the differences in the lived experiences of austerity for people who have mental health problems in different areas of Stockton-on-Tees?

3. How have mental health and public services in Stockton-on-Tees been affected by austerity and how have they responded to these challenges?

There has been little research to date into the effects of austerity on health inequalities and what has been undertaken has mainly centred on the effects at a national population level (Suhrcke and Stuckler, 2012; Coope et al, 2014; Barr et al, 2015a; Barr et al, 2015b); little consideration has been given to the effects on health inequalities at the regional or local levels (Bambra, 2013). Consequently there is a gap in knowledge regarding of the effects on inequalities in mental health. This thesis addresses that gap in the literature. It is also the first UK study to statistically quantify the relative contribution of material, psychosocial and behavioural factors to explain the gap in mental health and wellbeing between the most and least deprived neighbourhoods. Furthermore, whilst there is an emerging body of qualitative research exploring the impact of austerity measures (e.g. Patrick, 2015; Garthwaite, 2014; Pemberton et al, 2014), this project focuses specifically on the experiences of people who report having mental health problems, examining inequalities in the lived experiences of austerity between people living in deprived and affluent neighbourhoods Finally, there has to date been little academic research exploring stakeholders' perspectives on the impact of austerity on services, and this forms the final strand of this project.

This thesis offers an innovative and rigorous case study design using a mixed methods approach. In a similar tradition to Jahoda et al (1972), who built up a 'sociography' of mass unemployment in a town in Austria, I build a case exploring inequalities in mental health, and the impact of austerity, in Stockton-on-Tees. Whilst most research in this field uses either large datasets or small qualitative research, I bring together both approaches to investigate this issue. This has allowed me to consider issues of both structure *and* agency, evidencing

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the inequalities that exist in Stockton-on-Tees, but also how people experience those inequalities in their lives, how they react to them and what they do to cope. The thesis considers the 'umbrella' of mental health, looking both at inequalities in general mental health and well-being but also at the differences in experience of people who report having mental health problems in more and less deprived areas. This has enabled me to provide insight into how social conditions can have a profound impact on mental health, for those who do and do not report having problems with their mental health.

This thesis contributes important evidence towards the relevance of social models of mental health, adding to the evidence base around how mental health inequalities are socially determined, and the importance of material inequalities to local inequalities in mental health. However in addition to this the thesis provides important insights into the impact that austerity measures are having on services and on the people who use them, with a specific focus on those who report having mental health problems. This provides insight into inequalities in lived experiences (and differences in experiences of austerity) between people with mental health problems in more or less deprived neighbourhoods. It also demonstrates the emotional harm that austerity is causing to people who have mental health problems. All of this is of course happening in a place that was already very unequal to begin with. The austerity programme is directly impacting on inequalities in mental health through worsening material deprivation for those on the lowest incomes, creating further hardship for people who were already managing on very little. This highlights both the importance and significance of place when attempting to understand inequalities in mental health.

A range of methods have been adopted to explore this case. A robust cross-sectional survey explored the gap in mental health and wellbeing. This utilised a multi-stage sampling strategy and a well-designed survey which included validated instruments to measure health. Inequalities in mental health and wellbeing, and their social determinants, have been

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analysed using a multi-level modelling approach that recognises the hierarchical nature of society and that has allowed an exploration of the relative contribution of the different determinants of mental health to the inequality gap. Secondly, semi-structured interviews have been completed with people who report having mental health problems in different neighbourhoods of Stockton-on-Tees, and with key stakeholders in the local authority. Some techniques from grounded theory methodology have been applied to code and analyse the data, although the broad framework adopted is more in keeping with Burawoy's (1998) Extended Case Method.

There are several key themes which arise from the research. I argue that, in the case of Stockton-on-Tees, there is significant social inequality and that it is this inequality that is driving the gap in mental health and wellbeing. People living in the least deprived parts of the local authority have a good quality of life: they have a reasonable income, more secure employment, live in good quality homes and safe neighbourhoods.   Money is a source of power: people are able to use their financial stability to make decisions that benefit their mental health, and conversely to break away from situations that are harming mental health. All of these factors contribute to people having a good level of general mental health and well-being. However, in the most deprived parts of the local authority, people face on-going challenges relating to deprivation: poverty, insecurity, benefit cuts, chronic stress, living in unsafe areas. These all take a toll on mental health. Whilst people have the ability to make decisions, and do so, those decisions become constrained by issues relating to financial hardship, often placing people in situations in which they feel powerless.

I argue that austerity is having a disproportionate impact on people from more deprived backgrounds by compounding structural inequalities in the area. This in turn is leading to worsening financial situations and creating chronic levels of stress. Austerity is also impacting on service provision in the local authority, impacting on the support that is available to people and leading to a climate in which services are tasked with responding to

increased demand with fewer resources to meet that demand. This inevitably has a negative impact, both on services and those who use them.

For those who are experiencing mental health problems and are in receipt of out of work benefits, I argue that stress induced by the benefits system is damaging mental health and effectively keeping people in distress. On-going uncertainty, and a relentless process of assessment and re-assessment, is causing significant harm. However, it is not just material (and related psychosocial) factors alone which impact on people's mental health. Multiple factors interact to impact on mental health, including experiences such as abuse, grief, and the interaction between physical and mental health. Mental health problems also occur (although are less prevalent) in the least deprived areas, and people face significant challenges dealing with these issues in their lives. Despite this, it is argued that factors relating to deprivation compound the difficulties people have with their mental health, creating additional levels of stress and anxiety, making life incredibly challenging for some. People will, however, do what they can to survive. This thesis broadly argues for the need to adopt perspectives in mental health that recognise the social conditions under which people live, the realities of the material hardships that people can face in their everyday lives, and how these ultimately impact on people's mental health. I show how these hardships are compounded by an aggressive programme of cuts that are disproportionately impacting on those on the lowest incomes and living in the most deprived areas.

Structure of the Thesis

Following on from this introductory chapter, **Chapter Two** explores the current evidence base around mental health, inequality, and the impact of the global financial crisis, and resulting austerity measures, on mental health. The chapter begins by discussing different approaches towards mental health and mental distress, highlighting tensions around

language and dominant bio-medical approaches towards mental health. Issues of power and powerlessness are explored, alongside the intersecting oppressions people can face. Different theoretical understandings of mental wellbeing are highlighted. The chapter then moves on to explore health inequalities, social gradients in health, and explanatory accounts that explain why pervasive gaps in health exist. Spatial inequalities in health are discussed, incorporating geographical debates around context/composition. The chapter then moves on to explore the global financial crisis and how the resulting politics of austerity have impacted on inequalities in mental health. I explore issues around poverty, deprivation, and social inequality in the United Kingdom, highlighting how features of the austerity programme (in particular the welfare cuts) are impacting on those inequalities and on people's everyday lived experiences. I explore how public spending cuts are impacting on mental health and public services in the United Kingdom, before concluding by introducing the case under study, Stockton-on-Tees.

In **Chapter Three** I outline the methodological approach that I took to the project, my research aims and objectives, and the rationale for using the methods that I chose. As I have used a mixed methods approach, there is a consideration of the particular issues around combining methods, and a discussion of the epistemological considerations underpinning different types of methods. I argue that the combination of methods can best be achieved under a critical realist framework. I also show how the Extended Case Method approach has informed my methodology. Each research method is presented in turn, and there is also a discussion around issues of reflexivity, as well as ethical considerations.

Chapter Four presents the findings from the cross-sectional survey, exploring the gap in mental health between people from the most and least deprived areas of Stockton-on-Tees. I outline the multi-level modelling approach applied to the data. The key finding of this chapter is that there is a significant gap in mental health and wellbeing in Stockton-on-Tees, and that material and psychosocial factors are driving this gap. Multiple factors are shown to

interact with each other to impact on mental health and wellbeing. This includes socioeconomic factors such as household income and receipt of housing benefit, an impact of the physical environment that people are living in, psychosocial factors such as feeling connected with others, and more behavioural aspects such as engagement in physical exercise. The chapter shows how the combination and interaction of these factors have a cumulative impact on mental health. The findings are considered in the context of an austerity programme that is widening social inequality, and the implications for inequalities in mental health.

Chapter Five explores how people experience these inequalities in their everyday lives, and discusses the contrasting experiences of people in different neighbourhoods of the local authority. This chapter outlines the lived experiences of those who identify as having mental health problems. Amongst the themes are the role of agency, what people do about the inequality facing them, and how they survive the circumstances confronting them in their lives. A key finding is that people often faced multiple challenges and issues: these made life extremely challenging for some of the people in the study, although they used numerous strategies to cope and also presented some positive narratives, such as strong attachments to the communities where they lived. Key differences between people living in different parts of the local authority were revealed. This included: differences in income, and the impact that financial stability (or lack of it) had on mental health; experiences of the benefits system and welfare cuts; employment, including differences in work trajectories, the role of insecurity, and the relationship between employment and mental and physical health; and differences in the neighbourhoods that people were living in, which included experiences of social problems and the quality of housing.

Power and powerlessness emerged as key themes in participants' accounts and are discussed in the second section of chapter five. It is argued that whilst money was a source of power for those from least deprived areas, that people coming from more deprived

backgrounds, and more deprived areas, were often placed in situations in which they felt powerless, including in their experiences with the benefits system and other agencies. The strategies that people used to cope with this lack of power are highlighted. Amongst these were anger as a coping strategy, and advocacy as a means to challenge unfair decisions. Chapter five provides evidence that austerity is disproportionately impacting on the lives of people from more deprived backgrounds, through worsening material deprivation, and stress induced by dealing with the benefits system.

Chapter Six explores services and their relationship with austerity, presenting the findings from the interviews with key stakeholders. The central finding of this chapter was the twin problem of increasing demand, alongside fewer resources to meet that demand. This was reported as having a significant impact across the spectrum of services in the local authority. These issues were revealed in challenges for the local authority, mental health services, and the voluntary sector, including advocacy and welfare advice agencies. The tensions that came from these increased pressures created challenges for services, and had an adverse impact on practitioners. Further themes emerged around the detrimental impact of the welfare cuts, with practitioners outlining significant concerns about the financial and emotional harms wrought by the benefits system, and the disproportionate impact of the austerity programme on deprived communities.

Finally in **Chapter Seven** I triangulate the findings from all three results chapters and outline the main themes emerging out of this project. Centrally, I argue that the social inequalities in the local authority are driving inequalities in mental health. Whilst the lives people lead are complex, and numerous factors interact to impact on their mental health, I argue that factors relating to material deprivation are the key determinants of mental health and compound and exacerbate the difficulties that people are facing. Austerity measures aggravate pre-existing structural inequalities, worsening deprivation for those on the lowest incomes and creating increased and chronic levels of stress. I then discuss how the findings as a whole link in

with the wider research literature, and situate my contribution to the evidence on the social determinants of mental health and the impact of austerity on local inequalities in mental health. Finally, I explore avenues for further research arising out of the project, followed by key recommendations for policy makers. I conclude with some comments on austerity and its impact on mental health.

Chapter 2 Review of the Literature

Introduction

In this section I undertake a review of the literature relating to mental health, social inequality, and the impact of austerity measures (such as the cuts to public expenditure and cuts in social security) on the social landscape in the United Kingdom. I begin by exploring different approaches to understanding mental health, considering the importance of language, and exploring social models of mental distress. Issues relating to power and powerlessness are considered. Broader definitions of mental health and wellbeing are then explored.   The review then discusses the literature around health inequalities, the social gradient of health, and health and place, including debates around spatial inequalities and the social determinants of mental health. I discuss the global financial crisis and the literature to date around the impact of recessions and austerity on health inequalities. I then move on to explore the UK since 2010, looking broadly at the literature relating to poverty and deprivation, inequalities in wealth and income, welfare cuts, lived experiences of austerity, and the impact of spending cuts on mental health services.   In the final part of this chapter I highlight Stockton-on-Tees, which will be the case under study in this research project.

Approaches and Definitions in the Literature around Mental Health

It seems a good place to start to look at approaches in mental health, and how to define mental health and mental wellbeing. These are all contested terms. Language and terminology are important because they represent an underlying perspective of how we understand mental health. Using the term *'mental illness'*, for instance, reinforces the dominance of the medical model, viewing mental health problems in the same manner as

physical illnesses that can be diagnosed, labelled and treated (Burstow, 2013).   This thesis adopts a more critical perspective of mental health, and in this section I will draw on some of the literature that supports this view, taking a critical stance on the diagnostic labelling of mental health problems. This thesis is exploring the *umbrella* of mental health, looking at general mental health and wellbeing, but also at the experiences of people who report having mental health problems. As such it is necessary to look at debates around mental health, including approaches towards experiences of mental distress, but also at more general definitions of mental health and wellbeing. The section begins with a consideration of different approaches, tackles the concepts of power and powerlessness, and then moves on to explore more general definitions of mental health and wellbeing.

Approaches to Mental Distress

There are numerous perspectives in mental health, although in the past 30 years mental health problems have increasingly become framed as 'mental illnesses', and bio-medical explanatory models have come to dominate conventional understandings (Beresford et al, 2010).   These bio-medical models began to take greater precedence following the publication of the psychiatric diagnostic manual, the DSM-III, in 1980: this represented a historical shift of focus in mental health towards the "*broken brains and chemical imbalances*" discourses of diagnostic psychiatry (Lewis, 2009: 153). The DSM-III was an attempt by the psychiatric profession to give psychiatry more scientific rigour, embracing symptom-based diagnostic criteria for 'mental disorders' (Horwitz and Wakefield, 2007). A whole new raft of disorders was created as a result (Lane, 2007).   Bio-medical models see mental health problems as resulting primarily from problems within the individual, such as depression being 'caused' by a chemical imbalance of neurotransmitters in the brain. These approaches carry with them the idea that 'mental illnesses' can be identified and classified in the same way as physical illnesses, diagnosed by definable syndromes and clusters of symptoms (Dallos, 1996). Treatment is at the level of the individual, focused on fixing faulty

brain chemistry or faulty cognitions (Dallos, 1996). The place of psychiatric medication in treatment is intimately connected with this world-view (Wilson et al, 2008).

Bio-medical approaches are problematic for several reasons. Beresford (2005) argues that they are *pathologising:* they imply both that something is wrong with the person, and that something is wrong with their experiences, behaviour and perceptions. They also create an 'us and them' dichotomy (Tew, 2005), positioning people who are experiencing mental health problems as being *other* to the rest of 'normal' society, rather than as people whose experiences can be positioned along the same spectrum of experience. The clinical labels that are applied to people's experiences can themselves be stigmatising (Menzies et al, 2013; Shimrat, 2013). The labels are also social constructions: Lane (2007), for instance, discusses how certain human emotions became defined as psychiatric disorders by the psychiatric profession, such as shyness becoming constructed as *social anxiety disorder*, and grief as symptomatic of *clinical depression.* These social constructions serve as an example of the *medicalisation of life* that Ilich (1976) discusses in 'Medical Nemesis': in this he argues that the medical profession have vested interests in creating sickness, and that medical intervention has led to a society that has in fact become less healthy as a result. The field of mental health is a clear example of this pathologisation of normal human experience.

Morrow (2013) argues that biomedical models are tied in to the contemporary neoliberal ideology in political, economic and social life, focusing on individualistic understandings of experiences that are in fact the outcome of complex social problems. Despite clear research linking mental health problems to social inequalities such as poverty, racism, and homelessness, these social and structural determinants are marginalised in favour of approaches which focus on the individual (Morrow, 2013). Social perspectives provide an alternative to the dominant medical models, incorporating a consideration of the social determinants of mental health. Although there is no clear definition of a social model of

mental health (Tew, 2005), these approaches recognise mental health as being affected by broader social and environmental factors (Beresford et al, 2010). Tew (2005: 16) argues that "*mental distress must be seen as situated within a continuum of everyday lived experience*". Social models of mental health can incorporate this degree of *normality* into our understandings of mental health: they do not position people as outsiders with abnormal experiences, but instead as people who are responding to experiences and trauma in their lives. People who are living with mental health problems often link their onset with social events or experiences such as abuse or trauma: within a social perspective these become '*meaningful responses to sequences of often horrendous life experiences*' (Tew, 2005: 22).

There is a strong degree of support for more socially oriented models from mental health service users (Beresford et al, 2010). These recognise the social and structural determinants of mental health and accept that experiences of inequality and oppression can lead to mental health problems, as opposed to explanations which focus exclusively on individuals. This thesis explicitly follows a social perspective, taking a critical stance around the dominant medical models of mental health. As the language used reflects underlying assumptions (Burstow, 2013), I reject the term 'mental illness' and also do not use psychiatric diagnostic labels (unless in quotations when participants themselves have referred to them). This is because I take the position that those labels are problematic social constructions. Although 'madness' is a term that is being reclaimed by sectors of the mental health survivor movement, in particular within the emerging discipline of Mad Studies (e.g. LeFrancois, Reaume, and Menzies 2013), it is not a term that is embraced by everyone in the mental health community: some continue to perceive it as a derogotary term (Beresford et al, 2010). My personal view is that to define oneself as 'Mad' is to take an overtly political standpoint on issues relating to the mental health system. I did not feel it was appropriate to describe other people's experiences in terms of the language of madness, in particular as that language may not have been accepted, or recognised, by the people I interviewed, and therefore would not reflect how they viewed their own experiences. Alternatively I have

adopted the terms 'mental distress' and 'mental health problems' to describe people's experiences. These recognise the reality of people's experiences however aim to avoid giving legitimacy to psychiatric diagnostic labelling.

Alongside the different terminology and approaches used to describe mental health problems, there are also – relatedly – numerous perspectives, and on-going debates, around how mental health problems are defined. These range from the psychiatry focused cluster of diagnosable symptoms that have been discussed, to 'abnormal' behaviours and cognitions adopted by the psychological profession (Pilgrim and Rogers, 1999), to more sociologically informed perspectives such as labelling theory (Goffman, 1991). Pilgrim and Rogers (1999) advocate a critical realist approach, a position in which social reality is recognised as real, however that this material reality constrains action but does not determine it. People transform and reproduce that reality in their everyday lives. Critical realism is able to accommodate the reality of mental health problems, alongside a critical analysis of the interests that are served by the way mental health problems are conceptualised (Pilgrim and Rogers, 1999). This is the approach that is most consistent with my view. I understand mental health problems as real, however as discussed I am also critical of the dominance of psychiatric approaches to labelling. I recognise that people construct their own experiences and choose whether to define themselves as having a mental health problem, and whether they agree with the specific labels that have been applied to their experiences. Within this thesis, the people I interview with mental health problems are those who have identified themselves as such.

Power and Powerlessness

Having briefly touched on the role of inequality and oppression in mental distress, it is important to look at understandings of power and powerlessness. The concept of power is

one that is largely absent from bio-medical approaches in mental health, however there are strong links between experiences of oppression, inequality, abuse, and mental distress (Tew, 2005). People can face multiple and intersecting oppressions. This includes facing increased powerlessness as a result, for instance, of intersections between gender, sexuality, and ethnicity (Masterson and Owen, 2006).   People who are living with systematic forms of oppression are more likely to experience mental health problems (Tew, 2005). Marginalised groups are also at greater risk of having mental health problems, including people from black, Asian and minority ethnic groups, and people from the lesbian, gay, bisexual and transgender community (Mental Health Taskforce, 2016). Social inequalities in mental health can be seen as *intersectional*, where multiple aspects of identity, such as gender, ethnicity and class, interact to impact on mental health (Hill, 2016). Further, for those whose mental distress reaches a point where they become labelled as mentally ill, this can then lead to people being subjected to added levels of oppression by nature of the stigmatising labels that have been applied to them.   This includes those labels (such as schizophrenia) coming to define the whole person (Goffman, 1991).

How do we understand power and powerlessness as concepts?   Masterson and Owen (2006: 24) discuss a socioeconomic definition of power, in which power emerges through its '*unequal distribution between those who experience poverty… and those who do not'*. Power is linked to access and control over resources in society, such as access to financial resources, opportunities and structures. This power is distributed unevenly amongst a minority of the population. Tew (2006) argues further that power is a *social relation* of oppression*.   Certain groups in society have privileged access to resources and are therefore able to exercise 'power over' others, for instance in regards to economic exploitation. They use processes of 'othering' to maintain this power over other groups. These relations of oppression may also become internalised by those who are being oppressed, as people take on attributes of inferiority that have been applied to them by dominant groups (Tew, 2006). Freire (1970: 38-39) describes this process: '*So often do they*

hear that they are good for nothing, know nothing and are incapable of learning anything,

that they are sick, lazy and unproductive, that in the end they become convinced of their own

unfitness'.

Power can be seen as a dynamic social relation that operates at various scales, from *'the*

systematic patterning of the social whole, through the more local structuring of interpersonal

identities, to the construction and organization of personal identities (the internalisation of

power relations)'(Tew, 2006:40). Power can work to either open up or close off opportunities

for individuals or social groups; this includes access to resources and social or economic

participation, and developing personal identities and capabilities.   There are complex and

overlapping forms of power relations. Tew suggests that these can be separated into power

relations that involve exerting *'power over'* others, and others involving *'power together'*.

Both of these relations can be positive or negative applications of power. So, for instance, a

group of people can use a co-operative form of 'power together', using collective action and

sharing resources as a form of challenging oppression. However, a group could also use

'power together', with the purpose of excluding or suppressing another group.

Despite these issues of power, I would argue that people are not just 'done to': they have

agency to make their own decisions, although those decisions are made from a structurally

generated range of options. Those options that are available are not chosen by people but

are infringed upon them (Carter and New, 2004: 3). As such we can argue that people who

are in positions of powerlessness will try and challenge that with the resources that are

available.

Definitions of Mental Health and Wellbeing

As this thesis is considering the umbrella of mental health, it is also important to look at how

to define mental health and wellbeing. What is wellbeing? What does positive mental health

look like? Is there a difference between them? The World Health Organisation definition of health is of '*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*' (World Health Organisation, 1948). This is a holistic (although vague) view of health that moves away from disease specific medical models, and incorporates the concept of wellbeing into our understanding of health. The evidence around mental wellbeing suggests that people with higher levels achieve better outcomes across a range of areas, including better physical health, higher educational achievement and higher employment rates (Friedli, 2009). Mental wellbeing can be seen as a pathway through which the wider determinants of health, including deprivation and poverty, impact on health. Alongside this, however, mental health and mental wellbeing also need to be seen as outcomes in their own right, not just as mediators of this relationship (Rogers and Pilgrim, 2003).

There are, however, on-going debates around how we conceptualise both mental health and mental wellbeing. Additionally, concerns have been raised that defining wellbeing as being solely individual and psychological risks a similarly individualistic response: as such this may lead to a further shift in public health focus away from the social and environmental determinants (Atkinson, 2011). This has the potential to lead to the biomedical responses that have been discussed in relation to approaches towards people experiencing mental health problems: medication and therapy to 'treat' faulty cognitions and faulty brain chemistry (Dallos, 1996). There is therefore a need to ensure that although mental wellbeing may be defined by individual experience, that the social determinants are not marginalised in our understanding of what leads to good (or poor) mental wellbeing.

The World Health Organisation (2015) has conceptualised mental health as a state of wellbeing '*in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community*'. Huppert (2009) suggests further that mental well-being incorporates elements

both of feeling good (hedonic well-being) and functioning effectively (eudaimonic wellbeing). Feeling good involves positive feelings such as happiness, interest in life, contentment, confidence and engagement. Functioning effectively is about having a sense of purpose, feeling in control of life, the development of positive relationships, and the ability to cope with adverse events. Huppert argues that sustainable well-being does not require people to feel good all of the time; experiences of negative emotions, such as disappointment and grief, are a normal and healthy part of life. However she argues that psychological well-being becomes compromised when these negative emotions are extreme or long lasting, and get in the way of a person's ability to function in day to day life.

Three theoretical perspectives around the concept of wellbeing have been proposed: theory of needs, relative standards theory, and the capabilities approach (Fleuret and Atkinson, 2007). The theory of needs stems from the premise that satisfying needs is essential to wellbeing. This is linked for instance to Maslow's (1943) hierarchy of needs, wherein each level of needs has to be met before the individual is able to progress to the higher level. The relative standards theory, in contrast, views wellbeing as relative and subjective; what matters is how people perceive their own context *in relation* to that of others (Fleuret and Atkinson, 2007). The final approach is the theory of capability, developed by Amartya Sen, which bridges these conflicts between objective and subjective understandings of wellbeing. Within this approach, Sen (2008) argues that wellbeing is made up of *functionings*, which are a set of valuable states and activities (e.g. being adequately nourished, achieving self-respect, taking part in the life of a community). These sets of functionings have a relative value according to the individual; different functionings may have differing levels of importance depending on the person who is evaluating them. Capability is about the freedom the person has to be able to do these valuable activities or reach these valuable states (Sen, 2008).

As discussed, there are on-going debates around definitions of mental health and well-being. In terms of my own conceptualisation, I understand mental health as a state of mental well-being incorporating hedonic and eudaimonic features. However, alongside this, I recognise that well-being also incorporates a degree of subjectivity. Whilst mental wellbeing may include common states and activities, I accept Sen's (2008) argument that different individuals (and indeed different cultures) will attach differing levels of importance to these for their own overall well-being. For the purposes of my research project, however, I needed to apply a definition of mental well-being that could be objectively measured. Two contrasting measures were therefore used to assess mental health and well-being in the survey. Firstly, the Warwick Edinburgh Mental Well-Being Scale (WEMWBS) covers both hedonic and eudaimonic aspects of well-being and is more in keeping with my own understanding of well-being and the definition as outlined by Huppert (2009). The second measure, the SF-8, provides an alternative measure. It provides a general mental health score and has a greater focus on aspects related to functioning. These measures will be discussed more thoroughly in the methodology chapter.

Health Inequalities

Health inequalities can be defined as '*differences in health status or in the distribution of health determinants between different population groups'* (World Health Organisation, 2016). They are intimately related to socioeconomic inequalities (the gap between the rich and the poor) (Graham, 2007), although they can also incorporate inequalities by gender, ethnicity, and other intersecting aspects of people's identities (Hill, 2016). Graham and Kelly (2004) suggest three ways in which health inequalities can be conceptualised. This includes: a focus on the link between poverty and poor health (a focus on the health of the poorest in society); the gap in health between the worst off and the better off; and social gradients in health (differences in health across the whole spectrum of advantage and disadvantage). Whilst these approaches are complementary there are key differences between them. For

instance, a focus on the health of the poorest in society can obscure health inequalities between other social groups (Graham and Kelly, 2004). My project is focusing on the gap in mental health between people from the most and least deprived areas. Whilst it would also have been of interest to explore social gradients in mental health, the inequality gap in health is so pronounced in the case under study that exploring this was of central importance. In this section I explore the research relating to inequalities in health and mental health in the UK, looking at the literature on gaps and social gradients, the determinants of mental health, and spatial inequalities in health.

Gaps and Gradients in Health

Both physical and mental health follow a social gradient: the more favoured people are socially and economically, the better their health. People from higher socio-economic backgrounds will live longer (on average 7 years) and will live disability-free for longer (on average 17 years) than people from lower socioeconomic backgrounds (Marmot et al, 2010). This socioeconomic gap in life expectancy increased in Britain from the early 1970s onwards, in parallel with the upward trends in income inequality over the same period (Davey Smith et al, 2002). Although health improved for all groups up to 2009, the gap in health widened between the social classes, because the health of the rich improved at a quicker rate than that of the poor (House of Commons Health Committee, 2009). Alongside the link between socioeconomic class and physical health, the link between deprivation and mental health is also well-established (Williams, 2002). Mental health has been consistently associated with factors relating to material deprivation and to low income and socioeconomic status (Melzer et al, 2009). An individual's mental health is shaped by the environment he or she is living in, and people who come from more deprived backgrounds *are more likely to experience less favourable economic, social and environmental conditions throughout life and have access to fewer buffers and supports. These disadvantages start just before birth and tend to accumulate throughout life*" (WHO and Calouste Foundation, 2014: 17). There

is a cumulative effect from issues related to social deprivation and over time these impact on a person's mental health.

Poor mental health is both a cause and a consequence of social inequality (Pilgrim and Rogers, 1999). The social consequences of living in poverty, including the impact of unemployment, underemployment, debt, poor living conditions, and living in areas with high levels of deprivation, can increase vulnerability to developing mental ill-health (Rogers and Pilgrim, 2003). People who are experiencing mental health problems are at increased risk of poverty, due for instance to risks around discrimination at work preventing people from being able to secure and maintain employment (Evans-Lacko et al, 2013): between 30 and 40% of people who report having 'common' mental health problems in England are not in employment (Mental Health Taskforce, 2016), whilst between 85% and 95% of people who are labelled with schizophrenia are not in paid work (NICE, 2015). When people with mental health problems are in employment, they are over-represented in insecure, low paid work (Mental Health Taskforce, 2016), increasing inequality gaps in employment.

Explaining the Social Gradient

In the health inequalities literature, there are four main theories that account for the social gradient in health: materialist, psycho-social, behavioural/cultural and life course (Bambra, 2016; Bartley, 2008). These trace the cause of health inequalities to: structural inequalities in society and material and relative deprivation (Shaw et al, 2006); the differences between social groups in health-damaging behaviours such as smoking (Bartley, 2008); and the processes by which psychological demands including stress act as pathways to subsequent physical and mental ill-health (Brunner and Marmot, 2006; Bambra, 2011). The life-course perspective, which emerged in the 1980s, argues that the social distribution of health and disease results from processes of accumulating advantage and disadvantage (WHO and Calouste Gulbekian Foundation, 2014; Blane, 2006). There is a body of evidence lending

support to each of these theories and in practice they are not exclusive (e.g. Marmot and Wilkinson, 2006; Bambra, 2016). There are still disputes about the precise mechanisms which account for health inequalities, with many from a non-social scientific background still reluctant to accept the material and social drivers of inequalities in health.

Materialist explanations of health inequalities focus on poverty, relative deprivation, and processes of social exclusion, and how these impact on health outcomes and life expectancy (Shaw et al, 2006). They link income, and lack of resources and power, to the continuing gap in health. There is a long history of theorising in the UK that poverty impacts on health (Scrambler, 2012). The Black Report, which was published in 1980, revealed that despite access for all to a free health care system since the founding of the NHS, health inequalities continued to exist and indeed had widened (Bartley, 2008). The report tried to address these inequalities, proposing radical changes to health care and social policies. However the recommendations were not taken forward by the newly elected Conservative government. The Labour government in 1997 then commissioned a further inquiry, the Acheson Report, and subsequently set in motion a set of policy initiatives aiming to address these. However despite ten years of systematic policy action, health inequalities were not reduced. Although there were improvements in health and life expectancies for everyone within this period, the gap in health did not narrow (Mackenbach, 2010). The most recent report, the Marmot Review (Marmot et al, 2010), was a further attempt to investigate the most effective strategies for reducing health inequalities.   Despite systematic intervention by the New Labour administration throughout the 2000s, possibly the true barrier to addressing health inequalities has been that income inequality has continued to widen in the UK (Wilkinson and Pickett, 2010). As our society has grown ever more unequal, so too has our health.

Poverty acts as a constraint for many of the material conditions of life. This includes leading to limited access to adequate housing, inability to access good nutrition, constrained

opportunities to participate in society, and reduced access to goods and services (Shaw et al, 2006). Poorer health and higher rates of mortality are found in almost all studies of areas characterised by poverty and unemployment, and the link between income and health is evidenced in the vast majority of studies in this area (Bartley, 2008). Factors relating to material deprivation (such as the ability to pay for basic goods, activities, and services) have also been identified as significant determinants of mental health and wellbeing (Dreger et al, 2014). However, one difficulty with a purely materialist explanation of health lies in the social gradient itself: material explanations may account for the gap in health between people from the most and least deprived backgrounds, but how do they account for the differences between those at the top end of the socioeconomic scale? Bartley (2008) argues that this is also due to issues related to power, and that money is also an indication of where a person sits within the power structures of society. The health advantages an income will buy are not determined by money alone.

Psychosocial explanations of health inequalities provide an alternative explanation of how income inequalities impact on health, and may explain the social gradient. They emphasise people's experiences and emotions which give rise to acute and chronic levels of stress. Over time stress has a cumulative impact on the body, leading ultimately to physical and mental ill-health (Thoits, 2010; Marmot and Wilkinson, 2006). Where people have on-going, low level stress related, for instance, to living in poor housing, monotonous work, financial difficulties, and a lack of social support, these impact on the body. Chronic anxiety, low levels of self-esteem and a lack of control at work all appear to be damaging to physical and mental health (Brunner and Marmot, 2006).

Psychosocial perspectives also introduce the concept of relative deprivation: "*What matters is where we stand in relation to others in our own society*" (Wilkinson and Pickett, 2010: 25). Where a society has very unequal income distribution, people with relatively lower incomes perceive themselves as being of a lower status in the community. This self-perception

impacts on psychological well-being, leading to increased levels of stress, ultimately impacting on the body's immune and cardiovascular systems. Wilkinson and Pickett (2010) argue that there are 3 key sources of stress that impact on health: low social status, lack of friends, and stress in early life. They argue that these aspects all affect the degree to which as people we feel at ease and confident with each other. Chronic stress, in particular stress brought about by perceived low social status, is viewed as the key mechanism for how inequality leads to health inequalities.

Wilkinson and Pickett (2010) argue that material living standards in wealthy countries are now high enough that they are no longer direct determinants of health. This is highly contentious.   A report examining health inequalities in the north of England found that the gap in health between the north and south of England has continued to widen over the past four decades. Key differences in health are largely explained by socioeconomic factors, including higher rates of unemployment, lower incomes, adverse working conditions, poorer housing, and higher unsecured debt in the north compared to the south (Whitehead, 2014). Further, a nationwide study of poverty found that levels of social deprivation are rising to the levels found thirty years ago in the United Kingdom (PSE UK, 2013). Social deprivation has a very clear and growing presence in the UK, and these factors would feasibly feed into a material based model of inequalities in health.

Behavioural accounts of health inequalities focus on the things people do as individuals that are damaging to their health, and how certain groups of people are more likely than others to engage in health-damaging behaviours. So, for instance, smoking, drinking alcohol, and lack of exercise have all been found to be more predominant amongst people from deprived backgrounds than wealthy ones (Marmot, 2010).   There are 7 major risk factors for early mortality, 6 of which are related to diet and physical activity: high blood pressure, high serum cholesterol (related to high intake of saturated fat), tobacco use, high body mass index, low fruit and vegetable intake, low levels of physical activity, and high intake of alcohol

(Robertson, Brunner and Sheiham, 2006). Consumption of high amounts of alcohol appears to be a particular risk factor for mental ill-health (WHO and Calouste Gulbenkian Foundation, 2014).

Behavioural approaches are also a common theme running throughout public health interventions on health inequalities (e.g. Department of Health, 2011), despite an apparent widespread understanding that there are wider determinants of health. This is perhaps because they are cheaper than responses that tackle material inequalities. Increasing physical activity is a much-used piece of advice given to people to improve their mental health (e.g NHS, 2014), alongside 'eating healthy' and drinking less alcohol as a means to combat depression (NHS, 2014b). Differences in health promoting and health damaging behaviours between people from different socioeconomic backgrounds have been well-documented in research, although less explained has been why these differences exist (Bartley, 2008). It is also an approach that marginalises the wider structural determinants of health, by focusing in on the individual and by apportioning blame, and the impetus for change, firmly on that person. The gap in price between 'healthy' and 'unhealthy' foods has widened in the past decade, with healthy food now costing three times as much as unhealthy equivalents (Green, 2014). For people who are existing on a minimum income, 'eating well' may be an unattainable goal. A behavioural approach, whilst advocating a healthy diet as a strategy to maintain health, would fail to recognise this link with wider material inequalities.

The life course approach to health inequalities emerged in the 1980s and has as its premise the idea that health in later life is a result of complex interactions and processes that accumulate over time and start in the pre-natal period during pregnancy (Bartley, 2008). Physical and mental health are seen to reflect the patterns of social, psychological and biological advantages and disadvantages that are experienced by people as they move across the life course. These patterns are deeply shaped by the social and economic structures that individuals are positioned in (Bartley, 2008). This model can incorporate all

three of the previous explanations (material, behavioural and psycho-social) to account for how health inequalities exist, as it is a multi-faceted approach.

The WHO and Calouste Gulbenkian Foundation (2014) adopt a life course perspective to demonstrate the numerous complex factors that may interact to lead to good or bad mental health. They argue for an approach that suggests that mental health is determined by the level, frequency and duration of stressful events an individual experiences, and the extent to which these experiences are buffered by social supports and other individual coping strategies. So, for instance, they discuss a psychosocial perspective into how exposure to stressors during critical periods of early childhood (e.g. exposure to neglect, domestic violence and physical and psychological abuse) can have a significant impact on the development of biological stress mechanisms, which may impact on the immune system, cardiovascular function, respiratory systems and the brain. Young and older children from more deprived socioeconomic backgrounds are more likely to be exposed to poor living environments and stressful family contexts (WHO and Calouste Gulbenkian Foundation, 2014). As people move into working age, unemployment and poor quality employment become particular risk factors for mental health.   The risks of becoming unemployed and being in poor quality employment are significantly associated with socioeconomic class. Poverty is a major risk factor for mental health (WHO and Calouste Gulbenkian Foundation, 2014).

Health and Place

There are spatial inequalities in health: where you live impacts on the risks of developing ill-health, of poor mental health, and of dying prematurely. In the UK there is broadly a north-south divide, with the gap in health continuing to widen over the past four decades. This gap has equated to 1.5 million excess early deaths in the north compared to the rest of the country in that period (Whitehead, 2014). Deprived neighbourhoods in the north, for

instance, have worse health than comparable neighbourhoods in the rest of England   There are also health inequalities within regions, between different socio-economic groups (Whitehead, 2014).

Within the geographical literature, these spatial inequalities in health, and in mental health, have been discussed in relation to inter-related context and composition effects. Compositional variation results from the attributes of individuals that make up the population of an area (Curtis, 2004; Bambra, 2016). For instance, this includes the number of people in an area who are on unemployment or ill-health related benefits, levels of educational attainment, and socio-economic status. Inequalities in mental health are seen, therefore, to be caused by the number of people that live in an area that have these characteristics. Contextual variation, on the other hand, occurs when people with similar individual characteristics have different health outcomes in varying geographical areas. This suggests that where people live, and the spaces they inhabit, have an independent impact on health, above the impact of the individual characteristics of the people living there. Studies confirm that although health inequality is strongly related to composition, that this does not account for all of the variation in health outcomes, confirming that *place does matter* (Curtis, 2004).

Bambra (2016) suggests that health can differ by place because it is determined by the economic, social and physical environment of that place. Area-level economic factors that impact on health include area poverty rates, wages, and unemployment rates.   The mechanisms through which these factors impact on health are multiple: this includes, for instance, the nature of work that a person can access in that area, and an impact on the types of services available in the local area (more affluent areas may attract different services, such as physical activity opportunities). Features of the social environment that have effects on health include services such as childcare or transport, access to health care, the availability of good quality housing, and education.   Additionally, the local food environment (such as the availability of health food), alongside opportunities to access

opportunities for exercise (such as safe parks), are identified as important. Finally, features of the physical environment, such as access to green spaces, or exposure to waste or pollution, have also been widely recognised as important determinants of health (Bambra, 2016).

Curtis (2010) discusses the importance of the physical environments where people live in terms of *"therapeutic landscapes"* and *"landscapes of risk".*   Therapeutic landscapes (conceptualised by Gesler, 2003) are the landscapes people live in that may benefit mental health, such as natural green spaces. She argues that there are complex relationships between the material aspects of the environment, the ways these are perceived and understood, and their relation to human health. Although responses to natural landscapes are not universal, and are culturally specific, access to 'green' and 'blue' landscapes appears to be beneficial for mental health.   Conversely "*landscapes of risk*" describe places that are damaging to mental health, wherein for instance, persistent exposure to harmful physical surroundings may contribute to increased mental ill-health (Curtis, 2010). The literature explores elements of the natural environment that can promote good mental health (such as access to natural parks) (e.g. Cairns-Nagi and Bambra, 2013), and others related to a degraded physical environment (such as poor housing, pollution and run-down community areas), that have been shown to have a damaging impact (Curtis, 2010).

Although Macintyre et al (2002) argue for the continuing need to distinguish between contextual and compositional explanations for health variation, Cummins et al (2007) suggest instead that there is a false dualism between context and composition, and that the relationship between them is mutually reinforcing. They argue for the need to adopt a relational perspective, which sees the relationship between people and the spaces they inhabit as dynamic and changing over time. Places are conceptualised not as discrete spatial units, but instead as interacting nodes in networks.   Different 'contexts' have varying contributions, and there is a need therefore to map *'not just the life course of individuals, but*

also the social and economic trajectories of the places they inhabit' (Cummins et al, 2007: 1832). It is these different interactions and processes that occur between people and places that may contribute towards an understanding of spatial inequalities in health.   Warren and Garthwaite (2014:115) argue further that '*places have biographies in the same way as individuals*', suggesting that to understand the health of people living in a place, that we need to understand the place itself. Places are seen to have specific identities, made up of a history, a geography, industry and culture. The place that people live in cannot be separated out from the people living there, as one is so embedded within the other. The authors argue that research needs to move beyond the traditional context/composition debate to develop an understanding of place, '*not only the history, but the narratives of work, locality, culture and being*' (Warren and Garthwaite, 2014: 112).

Economic Crises, Austerity, and the Impact on Mental Health

In this section I explore how economic crises, and how the state *responds* to them, impact on population health and mental health, beginning with an discussion of the global financial crisis that took place at the end of 2007. I review how national and different international governments have responded to this. I explore the more general literature around the impact of past economic crises on mental health, and more specifically at how inequalities in mental health have been affected in the UK since 2008.

The Global Financial Crisis and the Resulting Politics of Austerity

Following the collapse of financial markets at the end of 2007, the initial months of 2008 witnessed the United States and European governments entering into an unprecedented rescue package for the banking sector. This followed concern that whole national economies would collapse (Stuckler and Basu, 2013). The common European response to this debt has been the new *politics of austerity*, which has seen widespread programmes of

public spending cuts (Kitson et al, 2011). Austerity refers to reducing budget deficits in economic downturns, by decreasing public expenditure and/or increasing taxes (Bambra, 2013). Across Europe the countries that have been most severely affected by the '*Great Recession'*, and resulting austerity responses, are those that are supported by IMF/EU/European Central Bank Programmes and those with clear fiscal problems experiencing market pressure. These include the countries of Portugal, Ireland, Italy, Greece and Spain. Less severely, although still heavily affected by the financial crisis, have been those countries in high levels of debt (at of over 60% of Gross Domestic Product). France, Germany and the United Kingdom fall within this category (UNICEF, 2014).

Austerity itself is not a new concept, although its meaning in terms of government policy has varied over time. For instance, in the post war period following 1945, the UK Labour government invoked austerity measures that included state redistribution on the grounds of need (MacLeavy, 2011), notably the founding of free health care for all in the form of the NHS. The UK austerity policies of today are being played out in a very different way, and under a very different ideological background. Whereas austerity driven policies following the Second World War led to a reduction in class and spatial inequalities in the period 1945-1975 (MacLeavy, 2011), today's austerity policies are arguably leading to a widening of social inequalities (Hall et al, 2013), and a further extension of the growing income inequality that has dominated the social landscape in the UK over the past few decades (Wilkinson and Pickett, 2010). Since the onset of the Thatcher administration at the end of 1970s, income and wealth inequalities have widened (Equality Trust, 2016). Austerity policies are arguably impacting on these inequalities by having a regressive impact on those on the lowest incomes (Hills, 2014).

In the UK, the Coalition's response to the financial crisis was to place the nation on a path of permanently lower spending, lower debt, and market led growth. Key targets have been public services, investment in public infrastructure and expenditure on welfare (Kitson et al,

2011). Whilst recession receded, the concept of austerity has remained.   Although austerity was presented by government as the only solution to the financial crisis, there is also a clear ideology underpinning the reforms. Austerity can be seen as a social construction, used as a tool to pursue the ideological aims of the current government. In the years following 2010, austerity became the dominant discourse in political life: tackling the 'budget deficit' was presented as paramount to the nation's survival, and the only way to achieve this was via heavy cuts in government spending. Hall et al (2013) argue that the financial crisis has been used as a justification to further entrench the neoliberal model that has been dominant over the past three decades. Austerity is serving to reinforce the distribution of wealth from the least to the most affluent sectors of society, and is involving a further restructuring of the state along market lines (Hall et al, 2013).   This includes, for instance, an increasing marketization of the NHS through the 2012 Health and Social Care Act.

The effects of austerity are not distributed evenly. In areas such as the North-East, which became increasingly dependent on public expenditure and public sector employment following deindustrialisation, successive waves of public spending cuts are impacting on spatial inequalities (Hudson, 2013).   Rates of precarious employment (e.g. 'zero hours contracts') have also continued to rise (MacInnes et al, 2015). Across the UK the local authorities hardest hit by government spending cuts are those in the most socially disadvantaged areas; this is disproportionately impacting on the availability of key services (Pearce, 2013).

Recessions and Mental Health

Economic downturns can have far reaching consequences, including rising unemployment rates, job insecurity, indebtedness, homelessness and a whole host of other social problems. Population level research confirms that recessions can have both negative and positive consequences on health.   Whilst suicide rates rise during recessions, there is also

an argument that recessions can be good for health, in that they can reduce levels of health-hazardous behaviours such as drinking alcohol and smoking (Suhrcke and Stuckler, 2012). In an analysis of the impact of increasing unemployment on mortality rates in 26 European countries between 1970 and 2009, Stuckler et al (2009) identified that for every 1% increase in unemployment, suicide rates rose by 0.79% in under 65s, homicide rates rose by 0.79% and deaths related to road traffic accidents reduced by 1.39%. Although rates of intentional violence (to self and to others) rise during recessions, people are less likely to drive and so rates of road traffic accidents have been shown to decrease. However Stuckler et al (2009) also found that populations varied in their response to economic downturns depending on levels of social protection and active labour market programmes (that support people in finding work and staying in work). So, for instance, in Sweden and Finland, there was no association between economic downturns, unemployment and poor health; this can be viewed as a result of the strong social protection systems in place in those countries (Stuckler et al, 2009).

Suhrcke and Stuckler (2012) reviewed the available evidence around whether the 2007/8 economic crisis would be detrimental to population health. They argued that it was mental health that would be most affected, proposing that specific indicators of poor mental health, such as suicide rates, would rise. This was in fact borne out by the data, with the male suicide rate increasing (Office for National Statistics, 2015). There is, however, a lack of evidence around how specific groups of people *within* populations are affected by economic downturns. The research on the health effects of recessions mainly centre on population averages; this does not consider how recessions impact on different subgroups of the population (Suhrcke and Stuckler, 2012). Some groups of people are likely to be more affected than others in terms of their impact on health, and it is this disproportionate impact that will be explored in this thesis.

Previous international research on welfare changes has shown that where welfare services are cut, this increases inequalities in mortality and morbidity: whilst overall population health is generally unaffected, cuts in welfare have a detrimental impact on the health of the poorest (e.g. Blakely et al, 2008; Shaw et al, 2005). Krieger et al (2008) explored US mortality data over a period of 42 years (from 1960 to 2002). They found that whilst inequalities in early deaths shrank between 1966 and 1980, from 1981 onwards the socioeconomic gaps in premature mortality widened. They argue that it was government programmes that led to these changes. Whilst the mid 1960's saw the "War on Poverty", civil rights legislation, and programmes such as Medicare, all of which contributed towards shrinking health inequalities, the 1980s then witnessed a general cutting back of welfare provisions in the United States, including cuts to public health, tax relief for the wealthy, and a growing inequality within society. Krieger et al (2008) argue that these economic and social policies contributed to widening health inequalities. Similarly in the UK, the rise of neoliberalism from 1979 led to a welfare retrenchment programme, rising income inequality, and widening inequalities in health (Collins et al, 2016; Shrecker and Bambra, 2015). Although overall population health has continued to improve since that time (everyone's health has improved), health inequalities between groups have not narrowed (Mackenbach, 2010).

Stuckler and Basu (2013) suggest further that where social safety nets are reduced, economic shocks can rapidly turn into health crises. They draw from findings from a century of data on recessions to demonstrate that *how* the state responds to economic crises determines their impact on public health. They discuss the mortality crisis in Russia following the transition to a capitalist economy in the 1990s. Between 1991 and 1994, life expectancy for men in Russia fell from 64 to 57 years of age. The men that were dying were young, working age men, and their deaths were related to alcohol poisoning, deaths from suicides, homicides and injuries, and heart attacks. Russia experienced a rapid transition from communism to a market based system, seeing radical privatization programmes in

combination with huge cuts to social welfare programmes. In Soviet Russia there had been a system of hundreds of 'monotowns', in which the whole town was dedicated to one single industry. Following rapid privatization, many of these towns saw their sole industry disappear virtually overnight. Inevitably this led to soaring increases in unemployment and whole towns were left without paid work. This is not so dissimilar to the former coalfields in the North East of England, in which the forced closure of mines in the 1980s and early 1990s had devastating and long lasting consequences. Stuckler and Basu (2013) argue that there were two key impacts of this rapid privatization programme in Russia: people lost both their jobs *and* the safety nets that could protect them at once. The resulting impact on health, and on life expectancy, was enormous. Other communist countries that followed a similar path, including Kazakhstan, Latvia and Lithuania, experienced marked drops in life expectancy, whilst those that took a slower and more gradual approach (e.g. Belarus) did not see the same degree of impact.

This pattern – of the harms invoked by austerity compared to the benefits of economic stimulus – is evidenced across a whole range of countries and in periods ranging from the Great Depression in the USA in the 1930s, to the East Asian financial crisis in the late 1990s, up to the current era of the Great Recession (Stuckler and Basu, 2013). The economic policies a government pursues matter enormously in determining health outcomes. Political and economic factors play a key role in shaping both contextual and compositional determinants of health, and places such as the North East of England, which has been economically, politically and socially marginalised by those in power, has seen the consequences in terms of the impact on health of the people living in the region (Bambra, 2016). My project will evidence how the austerity policies adopted by the government are shaping inequalities in mental health in Stockton-on-Tees, determining health outcomes in one place in the North East of England.

Inequalities in Mental Health since the Global Financial Crisis

There has been a body of research investigating, on a national and international level, how the global economic crisis of 2008 has impacted on population mental health. There is a strong link between rising unemployment and suicide rates (Barr et al, 2012). Chang et al (2013) undertook a time trend analysis of 54 countries, exploring the suicide rate in 2009 compared to what would have been expected based on 2000 to 2007 data. They found an excess suicide rate, in particular amongst men. Rising suicide rates were associated with increases in unemployment. Similarly, Reeves et al (2014) investigated increasing suicide rates across 20 European counties between 2007 and 2011. Male suicide rates were significantly associated with each percentage point increase in unemployment. This association was mitigated by spending on active labour market programmes, and high levels of social capital.

Coope et al (2014) focused on the suicide rate in England in the period 2008 to 2011, finding that the male suicide rate peaked in 2008. They investigated changes in suicide rates by area deprivation: although there was a three-fold difference in suicide rates between the most and least deprived areas of England, the authors found no evidence that the gap had widened. As such they argue that inequalities in mental health were not affected by the recession. Katikreddi et al (2012) similarly explored inequalities in population mental health in England from 1991 to 2010. Whilst they found a growing inequality in mental health between the most and least educated groups, and between people (men and women) from the most and least deprived areas of the country, the authors did not identify a widening of socio-economic inequalities in mental health as a result of the 2008 recession (up to 2010). Overall population mental health (in men particularly) deteriorated between 2008 and 2010, but the socioeconomic gap in mental health did not widen.

Contrary to this there is some evidence nationally of widening inequalities in mental health: most of these increases have been seen after 2011, which explains why earlier studies may not have identified these changes. Barr et al (2015) looked at trends in mental health between 2004 and 2013. Whilst rates of self-reported mental health problems rose between 2004 and 2009, the increase was significantly greater from 2009 to 2013, demonstrating a marked increase in self-reported mental health problems for both men and women. Further, the increase was greater for people with low levels of education (compared to high), and between those in and out of work, thus increasing inequality gaps in mental health. Barr et al (2015) looked at the association between trends in unemployment and rates of self-reported mental health problems. They found that although rising unemployment explained some of the increase in mental health problems, that these factors did not explain the majority of the increase. As such there are other factors contributing to widening inequalities in mental health.

Whilst population mental health usually declines during an economic recession and then recovers, this does not appear to have been the case in the current period: 2013 witnessed the highest male suicide rate since 2001 (ONS, 2015). Between 2010 and 2013, the largest increases in poor mental health (measured by suicide rates, self-reported mental health problems and anti-depressant prescription rates) have been in the most deprived areas, leading to increasing inequalities in mental health (Barr et al, 2015b). These increases can only partly be explained by rising unemployment, and it has been proposed that austerity measures, in particular welfare cuts, may explain these rising inequalities (Barr et al 2015; Barr et al, 2015b). This is principally as a result of reducing income amongst people on the lowest incomes in society. Barr et al (2015b) explored the relationship between reassessments under the Work Capability Assessment (the assessment for Employment and Support Allowance) and increasing indicators of poor mental health. They found that in areas where greater numbers of people were exposed to the reassessment process, that there were greater increases in suicides, self-reported mental health problems and anti-

depressant prescriptions. These associations were found to be independent of other characteristics known to affect mental health, such as area deprivation and unemployment rates. As such, the welfare changes themselves may be contributing to widening inequalities in mental health.

In summary, the research tells us that the period following the financial crisis was damaging for population mental health: rising unemployment that came about as a result of the global recession was associated with a rising male suicide rate. Indicators of poor mental health, including rates of self-reported mental health problems and anti-depressant prescriptions, have increased for both men and women. Studies that explored changes to mental health inequalities up to 2011 did not find evidence of the recession leading to widening socioeconomic inequalities in mental health. However, research that incorporates data from 2011 onwards suggests that these inequalities are indeed increasing, and it has been suggested that welfare cuts may be driving these widening inequalities in mental health. There is a gap in the literature in terms of how the current context is shaping local inequalities in mental health. However the local context is important. I have already outlined how there are significant spatial inequalities in health and mental health (Bambra, 2016; Whitehead, 2014), and in the next section I will consider how austerity is impacting on some places (and some people) more than others. This thesis will address this gap in the literature by exploring the inequality gap (and its determinants) between people from the most and least deprived neighbourhoods of one place in the North-East of England. Further, it will explore inequalities in the lived experiences of austerity between people with mental health problems from different neighbourhoods, showing how government policies are having a disproportionate impact, in turn exacerbating inequalities in people's lives.

Austerity and Inequality: The United Kingdom experience

'The most important problem we are facing now, today… is rising inequality'

(Robert Shiller, recipient of the 2013 Nobel Prize in Economics)

In this section I explore poverty and deprivation in the UK, looking at wealth and income inequalities, and different ways of measuring poverty. In considering the impact of austerity measures on socio-economic and spatial inequalities in mental health, it is important to contextualise this within the context of a nation that already had significant levels of inequality. It is also necessary to explore people's experiences of deprivation, and how the welfare cuts implemented since 2010 have impacted on people's material circumstances and lived experiences of poverty. These issues are explored, before I move on to consider the impact of austerity-driven spending cuts on mental health services in the UK.

The UK has been faced with high degrees of wealth and income inequality for the past thirty years (Equality Trust, 2016). Virtually all health and social problems are worse the more unequal societies are; this includes a strong association between income inequality and mental health (Wilkinson and Pickett, 2010). Alongside Canada and the United States, the UK has the highest levels of inequality in the rich world (Dorling, 2014). There are huge amounts of wealth in the UK but this is held by a tiny proportion of UK residents (Dorling, 2015). Whilst income inequality reduced slightly overall between 2007/8 and 2012/13, as a result of falling incomes across the board, this does not take into account growing income inequality with the top 1% (EHRC, 2015). This sector of society has fared well from the global financial crisis. This is in a period in which household incomes have risen more slowly than prices for virtually everyone else, leading to declining living standards for many (Hirsh, 2015), in particular low-income households of working age (Belfield et al, 2015).

There are different ways to measure poverty. The most commonly used measure in official statistics is a 'relative poverty' measure that identifies the number of people living in households with less than 60% of the median income in a current year. However 'absolute poverty' is a measure of income against a fixed line (Lupton, 2015): the Department of Work and Pensions measures absolute poverty as those falling below 60% of the 2010/11 median household income. These two measures tell us different things: whilst a reduction in the absolute poverty measure suggests that the incomes of low income families have risen in real terms, a fall in relative poverty implies that their incomes have risen only *relative* to middle-income earners (Belfield et al, 2015). This difference becomes important in periods where the median incomes of households fluctuate significantly, such as in the aftermath of the economic crisis, when real median incomes fell rapidly. At the same time the income of the poorest remained relatively stable, which meant that the data showed sharp declines in relative, but not absolute, poverty (Belfield et al, 2015).

The proportion of people classed as being in absolute poverty has stayed relatively stable in the past ten years (at around 21%) (Lupton, 2015). Belfield et al (2015) argue that poverty has been relatively stable since 2010 because rising employment, and falling numbers of workless households, have been important in preventing the absolute poverty rate from rising. However they suggest this stability masks a key finding: that in-work poverty has increased since 2009, as a result of falling earnings. Further, their estimates suggest that continuing benefit cuts will exert pressure on the absolute poverty rates, including for people who are in work (Belfield et al, 2015). What the data on poverty suggests is that the characteristics of those who are in poverty have changed in the past decade. Just over half of all people in poverty are now either in work or living with a working adult. There has also been a shift from older to younger people: whilst in 2003/4 there were more people aged over 65 in poverty than those aged 16-25, now the reverse is true. The poverty rate amongst disabled people has also risen (MacInnes et al, 2015).

These changes to the 'social portrait of poverty' reflect the impact of government policy on income over the life cycle. Hills (2014) discusses how social policy is driven by 'smoothing out' variations in incomes over the span of people's lives, arguing that the dominant effect of social spending in the UK is to redistribute income across people's own life cycles. People pay through taxes what they may need at other points in their lives. Under the New Labour administration between 1996/7 and 2010/11 there was a clear policy effort to reduce both child poverty and poverty in old age. New Labour increased benefits for older people, and put in place an increase in benefits and tax credits for families with children. Other working age benefits fell. Consequently, poverty rates for older people, children and their parents fell, whilst poverty rates for working age adults without children rose. After 2010, the Coalition government continued to protect most of the benefits for older people (such as the state pension and protection of the Winter Fuel Payment), but reduced benefits and services for other groups. Children were heavily affected, with reductions in child benefit and tax credits for parents, the abolition of the Education Maintenance Allowance, and cuts to council budgets for Early Years and Youth Services. Working age adults have been similarly hard hit, including for instance the targeting of disability and ill health related benefits, and changes to housing benefit and council tax benefits. The largest downward effects have been on low and middle income people of working age, and on low income children (Hills, 2014). So unsurprisingly we have seen child poverty rates on the increase: 300,000 children in the UK have fallen below the poverty line since 2012 (Butler, 2015).

In addition to the 'absolute' and 'relative' poverty measures, which focus solely on income, a different way to conceptualise poverty is to look at living standards and relative deprivation in terms of access to goods, services and activities. The Poverty and Social Exclusion UK Study (PSE UK, 2013) uses an approach pioneered by the 1983 Breadline Britain survey to measure relative deprivation in the UK. Deprivation is measured by what the general public feels is required for an acceptable standard of living. This is based on the consensual view of poverty as advanced by Peter Townsend (1979), in which he argues that:

Individuals, families and groups in the population can be said to be in poverty when they lack the resources to obtain the types of diet, participate in the activities, and have the living conditions and amenities which are customary, or at least widely encouraged or approved, in the societies to which they belong.

(Townsend, 1979:32)

Adopting the consensual approach, the Poverty and Social Exclusion survey identifies what is considered as minimally acceptable by the wider population, and then measures whether people are able to meet these minimum standards; those that fall below this are identified as being in poverty. For instance, some of the key basic priorities for adults in the 2012 study were seen as: the ability to heat living areas of the home; the ability to live in a damp-free home; and 2 meals a day. Poverty is about more than just access to material goods, and the standards also include the ability to participate in a range of activities. These minimum acceptable standards have changed over time. In all previous surveys, the ability to give presents to family and friends once a year was considered a necessity: in 2012 this was no longer true. Overall the population has grown less generous in what it feels is an acceptable standard of living (PSE UK, 2013). This reflects a hardening of public attitudes towards people who are in poverty (Pemberton et al, 2016). The survey findings indicate that living standards in the UK are worse than they have been for 30 years. 9% of households now cannot afford to keep their home adequately warm (compared to 3% in 1990), 10% live in damp households, 4% of children live with families who cannot afford to feed them properly (defined as 3 meals a day with one portion of meat/fish/vegetarian equivalent daily and a portion of fruit or vegetables daily), and 9% of children go without basic clothes items (e.g. a warm coat). Overall one quarter of the population of the UK have an unacceptably low standard of living (PSE UK, 2013).

Similar to the above approach, the Joseph Rowntree Foundation have a Minimum Income Standard, which is a figure based on the total of what members of the public feel people need (both items and services) to achieve a socially acceptable living standard (Hirsch, 2015). The 2015 analysis showed that living standards in the population have fallen. For working age households, neither people in receipt of out-of-work benefits, nor those working full time on the national minimum wage and with tax credits, reach the minimum income standard: a single person of working age reliant fully on benefits has just 40% of estimated income they would need; a single person working full time on the national minimum wage has enough to afford just 70% of the minimum income standards.

Since 2008 the adequacy of safety-net benefits have fallen for all groups. For instance, in 2008, families with children who were employed full time on the national minimum wage (with in-work benefits) received close to the minimum standard; in 2015 they fell 15% short of that level (Hirsh, 2015). For people at the lower end of the income scale, there is a growing subset of people whose material circumstances are significantly worse than they were 5 years ago. Increases in the cost of living (including the cost of food, fuel and rent) are having a much greater impact on overall finances, as these items make up a growing percentage of expenditure (MacInnes et al, 2015). Whilst the average person saw their income fall slightly during the recession and recover by 2014, for people at the lower end of the income spectrum, there has been a deterioration in their material circumstances.

The record on employment is mixed for the period 2010–2015. Whilst official unemployment rates fell significantly from 2.5 million to 1.8 million, and levels of household worklessness were the lowest on record (MacInnes et al, 2015), key groups have been negatively affected: unemployment increased amongst disabled people, there has been growing unemployment among the young relative to other age groups, and unemployment remained significantly higher for people from ethnic minorities, at over twice the rate of people from white ethnic groups (EHRC, 2015). This suggests widening inequalities in employment. Additionally,

growing numbers of people have been employed in precarious employment: there are increasing numbers of people on temporary contracts, higher rates of self-employment (with incomes of the self-employed falling), and overall pay, for all groups, is now lower than it was 5 years ago (MacInnes et al, 2015). The impact of the economic crisis has also added to spatial inequalities in employment. For the past twenty years, the north of England has had consistently lower levels of employment than the south. By 2006 this gap had almost been eliminated, however since the economic crisis this trend has been reversed: the north-south divide is now as wide as it was in the 1990s (Whitehead, 2014).

Welfare Cuts

The above exploration of poverty in the UK has demonstrated that, whilst official poverty rates have remained relatively stable since 2010, the material circumstances of the poorest members of society have deteriorated. A key explanation for this has been in the programme of "welfare reform" instigated by the coalition government. Virtually all of the welfare cuts (except the changes to child benefit for the wealthy) have been targeted at people who were already living in poverty (Duffy, 2013). This suggests that the welfare cuts, to both in and out-of-work benefits, have had a regressive impact, bearing most heavily on the poor (Hills, 2014).

The welfare bill has been a particular and severe target for government spending cuts, with a myriad of cuts that have been implemented. These can be seen as an extension of some of the welfare changes that were instigated under the New Labour administration (Macleavy, 2011), although there has been a process of intensification, of both the changes and the ideology underpinning them. The principal aim of the 'workfare' style changes, first introduced by Tony Blair, was to make support given by the state dependent on labour market input. These included 'welfare to work' programmes such as the New Deal, which required people to attend education, training or work experience in order to qualify for Job

Seekers Allowance.   New Labour also introduced a raft of measures that aimed to 'make work pay', such as the introduction of the minimum wage and working tax credits.   They introduced a firm focus on *responsibilitie*s of individuals to take the opportunities that would be provided to them to get into work, the state serving the function of '*helping people to help themselves*' (Blair, 2002).

The welfare cuts implemented from 2010 by the Coalition government continued this focus on increasing work incentives, and also extended private market provision (Taylor-Gooby and Stoker, 2011). The introduction in 2011 of the Work Programme is an example of this, where a range of organisations have been outsourced to get people who are unemployed back into paid employment.   Claimants under the Work Programme are mandated to attend certain 'work related activities' such as work trials and applying for jobs, and failure to comply with these can result in sanctioning (Pantazis, 2016).   A much more severe sanctioning regime was introduced in 2012, extending the principle of conditionality. Sanctions involve benefits being stopped for a set period for failure to comply with certain requirements, effectively leaving people with no income for periods of time (up to three years in some cases).   It is sanctions (alongside benefit delays and financial difficulties related to the bedroom tax and abolition of council tax relief) that are credited for the unparalleled rise in the use of food banks in the United Kingdom (O'Hara, 2013).

Coalition implemented changes also included harsher and more stringent medical tests for Employment and Support Allowance (Beatty and Fothergill, 2013). ESA is a benefit that was introduced in 2008 by the previous labour administration, replacing Incapacity Benefit.   The Work Capability Assessment (WCA) is a tool which assesses people for their eligibility for this benefit. Previous incapacity benefits claimants and any new claimants are assessed via the WCA. People can also be reassessed at intervals to identify if they are still eligible for the benefit. The WCA has come under heavy criticism since its inception, with its viability and credibility heavily criticised by the people assessed under it (Warren et al, 2014).

Mental health charities have led calls that the process is damaging people's mental health (Mind, 2012), and there have been media reports linking the WCA to numerous deaths (Warren et al, 2014).

The welfare cuts initiated from 2010 by the coalition government were numerous, and many individuals have been affected by multiple benefit cuts: it is those on the lowest incomes who are most heavily affected. It has also been the most deprived local authorities that have been hardest hit by the cuts. They hit poorer places harder because they have higher numbers of people who are reliant on benefits. An analysis of the impact of the welfare cuts between 2010 and 2016 found that the most heavily affected areas have been the older industrial areas of England, Scotland and Wales (e.g. North-East and North West England, Glasgow), less prosperous seaside towns (such as Blackpool), and some London boroughs (Beatty and Fothergill, 2016). Blackpool has lost £720 per working age adult as a result of the welfare cuts, Middlesbrough £550. This compares to Cambridge which lost £190 per adult (Beatty and Fothergill, 2016). The analysis shows how place is not neutral, that the welfare cuts are having an uneven spatial impact across different areas of the UK.

Everyday Lives: Poverty in Austere Times

The evidence about poverty at a national level suggests that, in particular for people on the lowest incomes, levels of material deprivation have worsened since 2010. The welfare cuts have particularly affected people on the lowest incomes, and also the poorest places. The North-East of England has been one of the hardest hit regions, precisely because it is one of the most deprived areas.   The voices of people who are living in poverty, and dealing with the effects of cuts to welfare and to services, are rarely heard, and the aim of this section is to review some of the qualitative literature that brings those voices to the fore. How are people being affected in their everyday lives? What are the challenges and strategies that people use to deal with this? One key question is whether people's experiences of poverty

have changed as result of the austerity programme, and in what way, or whether in effect it is just 'more of the same' for people who were already living on very low incomes. As already explained, the UK had high levels of inequality before the global economic crisis hit, and as such people's experiences now may not be markedly changed. Is that the case, or is the government's 'austerity programme' having an additional impact on people?

In the 'Life on a Low Income in Austere Times' study, Pemberton et al (2014) interviewed 62 people from three different areas of the UK (Birmingham, Glasgow and Gloucestershire), to explore the realities of living in poverty in a period of austerity. They found that people's experiences had worsened in the current era, arguing that the '*nature of poverty has not changed, but the extent of deprivation and the intensity of the associated emotional injury seems to have increased*' (Pemberton et al, 2014: 37-38). Three reasons are documented for this: greater material pressures; an increasing sense of insecurity; and the impact of pejorative political and media portrayals.

Since 2010 there have been increased financial pressures placed on people already living on a low income. Within the Pemberton et al study, participants spoke of the rising costs of living and the impact of these rising costs on household budgets that were already very fragile. Participants talked about the need to 'go without', about decisions such as 'heat or eat', about being unable to afford even basic necessities and having to make sacrifices so that their children would not go without. The difficulties created by managing on such a restrictive income were experienced as an endless and unremitting pressure. This led to a pervasive sense of insecurity for participants. They were insecure in respect of their income, but also faced insecurity in terms of precarious employment, and insecurity in the benefits system. The constant threat of sanctions and reassessments were an on-going source of stress for participants. Pemberton et al (2014) argue that these pressures ultimately had an emotional toll on participants, leading to high degrees of stress, anxiety, and depression. Finally, participants spoke of the increasingly stigmatising experiences of life on a low

income, including negative portrayals by the media and the government. This stigmatisation was perceived by participants to have worsened since the recession.

The welfare cuts have been accompanied by public and policy discourses prioritizing individual explanations for poverty, using well-worn neoliberal rhetoric linking poverty with family breakdown, addiction, unemployment and poor education. Other drivers of poverty, such as low pay, have not been included in this analysis (Pantazis, 2016). The welfare state has been positioned as problematic, seen to create continuing welfare dependency (Pantazis, 2016). There has been a process of 'othering' of people receiving welfare benefits, and of setting people apart into the new 'deserving' and 'undeserving' poor (Garthwaite, 2011). This othering reinforces social divisions and feeds into neoliberal ideologies of competitive individualism (Hall et al, 2013). This type of othering is not new, as stigmatisation of people in receipt of benefits is an endemic feature of most social security systems (Baumberg, 2016). However evidence suggests there has been a hardening of attitudes towards poverty in recent years. In an analysis of media coverage of benefit claimants from 1995 to 2011, Baumberg et al (2012) found that negative media representations of worklessness intensified in the period 2010/11, and in the PSE UK (2013) national study on poverty, the general public had much less generous views around what constituted a minimum standard of living. These increasingly harsh perceptions of people in poverty have led to an increasing stigmatisation of people in poverty.

Garthwaite (2014) discusses the increasingly negative portrayal of sick and disabled people in the media and in government rhetoric, and the impact that this has on people who are themselves disabled or sick. She undertook in-depth interviews with 25 long term sickness benefits recipients in the north-east of England during 2011, finding that these increasingly negative portrayals had a damaging impact on participants' self-esteem. Whilst participants felt increasing stigma about being in receipt of these types of benefits, it also led to divisions *between* people who were in receipt of sickness and disability benefits: participants had a

distinct 'us' and 'them' dichotomy, identifying themselves as 'deserving' but presenting narratives around those they knew who were 'undeserving'.   Participants also discussed significant levels of anxiety about the welfare reforms, including a '*fear of the brown envelope*', identifying a sense of powerlessness about the upcoming benefit changes (Garthwaite, 2014: 787)

Similarly, Patrick (2015) explored experiences of welfare cuts with a group of out of work benefit claimants between 2011 and 2013, finding, as with Pemberton et al (2014), that managing on a low income was extremely challenging, and that the welfare changes were harming people in respect of leading to increasing levels of stress, worry, and anxiety. Whilst dominant narratives serve to vilify those who are in receipt of certain benefits, portraying a view of people as being idle and 'workshy', Patrick found that managing on benefits in fact entailed a high degree of hard work. Participants spoke of needing to use labour-intensive strategies to get by on a very restricted budget. This included shopping on a daily basis for cheaper items from the reduced section of the supermarket, and searching around for the cheapest deals. They spoke of often going without food. Many participants had other roles and other responsibilities, such as being carers for other family members, volunteers, and parents. Participants did not have the 'culture of worklessness' that is commonly depicted in discourses around poverty (Pantazis, 2006), they retained aspirations to work and many followed the 'low no pay' cycle (Shildrick et al, 2012), moving in and out of low paid, insecure employment.

As with the large scale quantitative research identifying the impact of the financial recession and government policy on population mental health, one of the key themes emerging from the qualitative literature is the impact that the welfare cuts, and increasing material deprivation, is having on people's mental health.   The literature would suggest that increasing financial and employment insecurity, alongside benefits insecurity, are having a detrimental impact on people's mental health and wellbeing. There is a lack of academic

research exploring how the welfare cuts have impacted specifically on people who are experiencing problems with their mental health, although there is evidence from the voluntary sector that the welfare cuts are having a damaging impact on the mental health of this group of people (e.g. O'Hara, 2013). My research project will fill this gap in the literature. In the next section I review mental health services in the period of austerity, and the impact of cuts in public spending in this area.

Mental Health Support in a Period of Austerity

In the UK there is a broad (and confusing) spectrum of services in place for people who are experiencing problems with their mental health. 'Mental health services' can be defined as services that have been commissioned by the NHS and local authority commissioners, provided by the NHS, independent and voluntary sector services, and local authority services (Mental Health Foundation, 2013). NHS provided mental health services cover both community and hospital treatment, with a range of specialist provision including, for instance, community mental health teams, early intervention for psychosis teams, and crisis teams (NHS, 2016). Following the introduction of the 1990 Community Care Act, there has been a long term trend in mental health towards moving services and care away from institutions and into the community. This has led to an 'internal market' in health and social care, with care separated into 'commissioners' and 'providers' of care (Wilson et al, 2008). This has led to an increasing marketization within mental health, with a range of different providers commissioned to deliver services. The implementation of the 2012 Health and Social Care Act has extended these principles of marketization further, by moving the responsibility of commissioning services to local Clinical Commissioning Groups and opening the way for 'any willing provider' to supply services. This makes it possible now for the private sector, alongside third sector organisations, to compete directly for NHS services (Glover-Thomas, 2013).

Although there is a broad range of services there are large problems in access, with many people having difficulties accessing support or receiving no help at all (Mental Health Foundation, 2013). There is also a significant body of user literature criticising mental health services, including evidence from a literature of survivor accounts reflecting on how the current system is oppressive, and coercive, and often does not provide the type of support that people want or find helpful (e.g. Lee, 2013; Campbell, 2002). In this section I consider briefly how mental health services have been impacted by cuts to public spending, including the impact on social care, NHS mental health services, and the third sector.

The provision of social care in the United Kingdom has been radically affected since 2010. One of the primary functions of local government (over 60%) is to provide social care to children and adults, and as such this is a key area that has been targeted for funding cuts (Duffy, 2013). Local authorities are losing significant levels of funding for social care services (Lymbery, 2012) and this is disproportionately affecting more deprived areas (Kitson et al 2011). In an analysis of levels of social care provision in the UK between 2005/6 and 2012/13, Fernandez et al (2013) identified widespread reductions in the numbers of adults who received state funded social care. Overall there was a 26% reduction in the number of recipients of social care within this period; mental health social care saw a 21% reduction. People with mental health problems who require social care support have high levels of need and as such are highly vulnerable to the withdrawal of support services. The tightening up of eligibility criteria (Lymbery, 2012), including many local authorities only responding to levels of need that are 'substantial' or 'critical', can be seen as reflective of local governments that have been given no option but to make severe cuts to their budgets for social care. The outcome of this for individuals is that they have seen significant reductions in levels of support (with some losing support altogether) and increased charges for the services they do receive. This is alongside the reality of many people already facing reduced incomes as a result of welfare cuts.

NHS led mental health services continue to be significantly underfunded, despite mental ill-health being responsible for the largest proportion of the 'disease burden' in the United Kingdom (22.8%) (Bailey et al, 2013). This is also despite a commitment from the previous coalition government to improve funding for mental health (Wintour, 2014; Mattheys, 2015). Crisis mental health services are under increased strain. Despite a long term trend of moving away from hospital based treatment for mental health crises, there remains a need for in-patient services (Wilson et al, 2008). The closure of more than 1700 acute hospital beds from 2011 to 2013 has led to concerns that the demand for crisis services is far outstripping supply (McNicoll, 2013). There are simply not enough beds for people who need them. This means that some people are denied support when they need it; others are placed in inappropriate settings (such as prison cells) whilst they await placements, or sent to locations far from home because of a lack of appropriate facilities nearby (Mental Health Taskforce, 2016). It was demonstrated earlier how population mental health has been adversely affected since 2009 (Barr et al, 2015), this has led to increased demand for support from mental health services (McDaid and Knapp, 2010).

A report in 2016 by the independent Mental Health Taskforce to the NHS identified widespread problems across mental health services in England, and worsening outcomes in recent years (Mental Health Taskforce, 2016). Adult mental health services are under intense pressure, with a lack of staff, lack of resources, and an increasing demand. For those who access support, waiting times for appointments are unacceptably long, and services are increasing the thresholds for access. In 2014/15, bed occupancy for in-patient services had risen for the fourth consecutive year (to 94%), and the number of people detained under the Mental Health Act had continued to increase (Mental Health Taskforce, 2016). Similar concerns have been identified with CAMHS services (House of Commons Health Committee, 2014). Since 2010 the NHS has made real term reductions in investment in mental health services and has exacerbated the situation (in a sector which was already

subject to chronic underinvestment in services) for both young and older people alike (Thornicroft and Docherty, 2014).

Despite reduced funding for mental health services there have been some new initiatives in mental health, in particular with regards to 'talking therapies'. The Improving Access to Psychological Treatments (IAPT) programme began in 2008 and aimed to increase access to talking therapies across England, in particularly for people labelled with anxiety or depression. It was not without controversy, as it was also introduced with the underlying economic aim of '*helping people come off sick pay and benefits*' (Department of Health, 2011b: 5). There have been criticisms of this economic justification, concerns that it focuses solely on CBT, and ignores the evidence of contributory social and economic factors. The programmes have been criticised as failing to address the complex and intersecting issues that people are often dealing with (Marzillier and Hall, 2009).

Concerns have also been raised around the increasing use of psychological therapy in government 'workfare' programmes (Friedli and Steam, 2015), with for instance plans to co-locate IAPT therapists in 350 Job Centres (HM Treasury, 2015). This linking of psychological therapy with employment goals forms part of the wider neoliberal agenda in mental health. It implies that if someone is unable to find employment that this is a result of both personal failure and psychological deficit (Friedli and Steam, 2015), rather than any wider structural inequalities or barriers to employment, such as discrimination, that are faced by people experiencing mental distress (Evans-Lacko et al, 2013). Access to IAPT services has also been widely variable, with 6 days waiting time in the best performing areas and 124 days waiting times in the worst (Mental Health Taskforce, 2016).

The third sector has also been hit hard by funding cuts since 2010. This can be demonstrated in reduced funding for mental health services, alongside a range of other related services (Mind, 2011). O'Hara (2013) discusses the implication of funding cuts on a

whole host of community and voluntary organisations. For instance, there has been a significant reduction in funding for services for women such as domestic violence refuges, specialist support for women from BME backgrounds, and rape crisis centres. Mitchell et al (2013) further identified that austerity was impacting on LGBT services, with reports of increasing instability and reductions in funding. Reduced funding for services coincides with increased demand, with for instance a Mind-operated helpline for people who felt suicidal seeing a 30% increase in calls in the period from 2011/2012 to 2012/2013 (O'Hara, 2013).

Although there is evidence documenting the impact of austerity on service provision, there is a lack of academic research exploring stakeholder perspectives on the effects of these measures both on services and on the people who use them. Edwards et al (2013) undertook research estimating the overall impact of the welfare changes across the North East. Stakeholder perspectives were incorporated within the analysis, and although the findings identified that communities were struggling as a result of the changes, at the point of the interviews many of the key welfare changes were yet to be implemented. This thesis will build on the existing evidence base, exploring stakeholder perspectives on the impact of austerity – both on services and on communities – at the local level.

The Case of Stockton-on-Tees

In this final section of the literature review, I move on to explore the case under study. Stockton-on-Tees is located in Teesside, in the north-east of England. It was originally a market borough (and Stockton is still a market town), however from the 19th Century, iron working, shipbuilding and engineering prospered in Stockton-on-Tees (Beynon et al, 1994). This period saw the development of shipbuilding and railway industries, manufacturing and engineering, alongside iron and steel production. Industry was boosted in Stockton-on-Tees when the Stockton and Darlington railway opened in 1825. This was the first public railway

to use steam and the movement of coal became a prosperous industry. Its first line connected collieries in Shildon with Stockton and Darlington and the line was soon expanded. In the early 20th Century the chemicals industry also saw major development, with the formation of Imperial Chemical Industries (ICI) in Billingham in 1926.

Although there were cyclical crises in the industrial economy, such as the depression of the 1920s and 1930s leading to a collapse in demand for shipbuilding, by the mid-20th Century Teesside was 'among the most heavily industrialised regions of Western Europe' (Beynon et al, 1994: 24). By 1968, Head Wrightsons, a major industrial engineering firm, employed 6000 people in Stockton-on-Tees. From the 1970s onwards, however, recession, combined with large scale processes of deindustrialisation, led to rising unemployment and a severe decline in the old industrial economy. Although some industry remained, there was a shift towards a service economy, with an accompanying increase in flexible labour and low wage jobs (Beynon et al, 1994), and a significant growth in public sector employment. This shift in labour market was not fully successful however, with levels of unemployment remaining a significant problem (Beynon et al, 1994).

Today Stockton-on-Tees has a population of 191,600 residents (Office for National Statistics, 2011). 51% of the population is male and 49% female. The population is overwhelmingly white (93.4%) although there is a small Asian/Asian British population (Indian 0.8%, Pakistani 1.6%, Bangladeshi 0.1%, Chinese 0.5%) (Office for National Statistics, 2011). Most of the population of Stockton-on-Tees lives in the four principal towns of the borough: Stockton (the largest), followed by Billingham, Thornaby, and Yarm (Stockton-on-Tees Borough Council, 2011).

Following the global 2007/8 financial crisis, the recession that followed witnessed an above average rise in unemployment in Stockton-on-Tees (Nomis, 2012), alongside cuts in local authority spending and reductions in public sector employment (Hudson, 2013). Welfare cuts

have had a significant impact: the hardest hit places have been in the old industrial areas of England, Scotland and Wales, such as Glasgow, South Wales Valley, and the North-East and North-West of England (Beatty and Fothergill, 2016). This however masks inequalities *within* areas (Whitehead, 2014). Stockton has high levels of social inequality, with some areas of the borough being particularly affluent (e.g. Ingleby Barwick and Eaglescliffe) and others with high levels of deprivation (e.g. Hardwick, Stockton town centre). These areas are often in close proximity to one another. Figure 1 represents a map of Stockton-on-Tees, including the most and least deprived areas. There are 117 lower super output areas in Stockton-on-Tees, 34 of these (29%) are in the most deprived quintile of the country. 18 lower super output areas are in the most deprived 10%. At the other end of the spectrum, around 33% of people are in the top 20% nationally in terms of income (Joint Strategic Needs Assessment, 2013). Therefore Stockton has a relatively small 'middle' and large numbers of the population at either extreme.
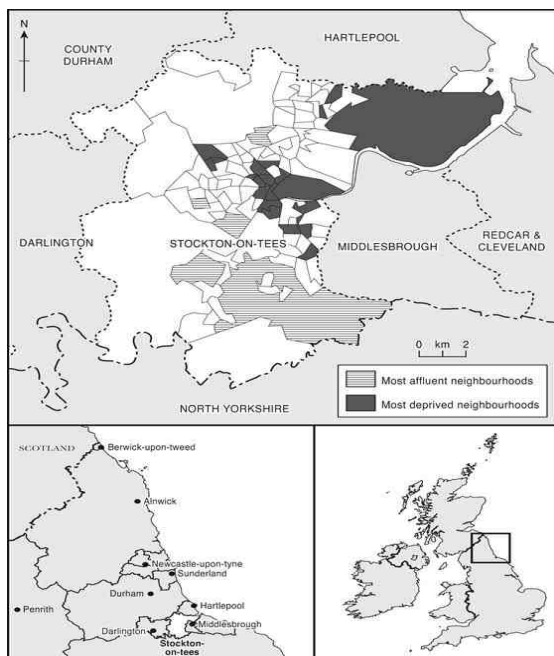
Figure 1: Maps of Stockton-on-Tees, including most and least deprived neighbourhoods

Unemployment remains a significant problem in the local authority (Nomis, 2015). The jobs density figure is defined as the number of jobs in an area divided by the resident population

aged 16-64 in that area. For example, a job density of 1.0 would mean that there is one job for every resident aged 16-64. In Stockton-on-Tees the jobs density figure is 0.73, suggesting a lack of jobs per working age resident (Nomis, 2015). Deprivation overall is slightly higher than the national average: 21.9% of children live in poverty, compared to 19.2% nationally (Public Health England, 2015), although again this masks inequalities within the local authority. Rates of teenage pregnancy, educational attainment and smoking are all worse than the national average, whilst 26.1% of adults are classified as obese and rates of self-harm related hospital stays are significantly worse than the national average (Public Health England, 2015). An estimated 24,000 people in Stockton are reported as having a mental health problem; these rates of mental ill-health are higher than the national average, and have increased since 2010/11 (Joint Strategic Needs Assessment 2013).

Commencing in 2013/14, quarterly reports on the welfare changes have been produced for the Cabinet in local government (Stockton on Tees Borough Council, 2016). The data presents a complex and sometimes nuanced picture of how welfare cuts, and related indicators, are impacting on residents in the local authority. Recent data shows that in some areas, indicators may be improving, whilst in others they continue to remain problematic. In employment for instance, greater numbers of the working age population are now in paid work (77.30% in the period October 2014 to September 2015 compared to 70.3% from January to December 2014). The figures do not, however, provide a breakdown of whether that increase has been in full or part time employment. The number of JSA claimants has also fallen since 2013 (from 4.6% of the population in 2013/14, to 3.2% in 2014/15, and then to 3.0% in December 2015).

However, in 2015/16 a significant number of residents remained affected by the bedroom tax; this was only a small decrease from the numbers affected in 2013/14 (Stockton on Tees Borough Council, 2016). During 2015, 1,371 people used food banks in Stockton-on-Tees, with 225 people (16%) having used food banks on three or more occasions. This suggests

that of those people who need to use a food bank, there is a small group with on-going, significant difficulties relating to food poverty. Statutory homelessness (homelessness that has been officially defined as such and meets the criteria for entitlement to support from the local authority) is not a large problem in Stockton-on-Tees. Levels of acquisitive crime have, however, increased dramatically: theft increased by 20% in one year (from 2014/15 to 2015/16), and robberies by 65.3%. There has also been a 37% increase in the number of incidents of domestic violence recorded as crime in the same period (Stockton-on-Tees Borough Council, 2016). This is alongside significant cuts in police funding in the region and heavy reductions in the numbers of police officers (Blackburn, 2014).

Conclusion

This literature review has shown us that mental health is socially determined in the same way as physical health. There are significant inequalities in mental health across the UK, and whilst evidence suggests that poverty and deprivation are significant drivers of poor mental health, there is still debate around the precise mechanisms leading to these inequality gaps. The literature suggests that nationally, austerity measures are impacting on spatial and socioeconomic inequalities, having a regressive impact as they disproportionately affect the most deprived communities, and those on the lowest incomes. However there is little research into the effects of the current austerity programme on health inequalities, and what there has been has mainly focused on inequalities at a national level. There is particularly a gap in the literature around the effects on inequalities in mental health. This project is focusing down to a local level, using an innovative case study approach to explore inequalities in mental health in Stockton-on-Tees.

I explore – *firstly* – the gap in mental health and wellbeing between the most and least deprived neighbourhoods, and what is causing this gap. I have demonstrated the

importance of the local context to health: the UK is massively divided, with significant gaps in health between regions, and also within regions and within towns and cities (Whitehead, 2014; Bambra, 2016). Place matters. Stockton-on-Tees is a particularly important case because it has the highest spatial health inequalities in England, both for men (at a 17.3 year difference in life expectancy at birth) and for women (11.4 year gap in life expectancy) (Public Health England, 2015). It is therefore of importance to consider how the local context is shaping inequalities in mental health. Uniquely for UK research, a social determinants of mental health model will be applied, considering the relative contributions of material, psychosocial and behavioural determinants to the gap in mental health and wellbeing.

The literature review has identified how austerity measures such as the welfare cuts have impacted on the social and geographical landscape nationally (Beatty and Fothergill, 2016), and on the lives of people who are living on a low income (Pemberton et al, 2016; Garthwaite, 2014). There has been a lack of qualitative research exploring the specific experiences of austerity for people with mental health problems, and this project will add to the wider evidence base by – *secondly* – considering inequalities in the lives of people in Stockon-on-Tees, and how people with mental health problems are being affected during austerity. By exploring the commonalities and differences in experience, it will consider inequalities in the lived experiences of austerity between people with mental health problems in different parts of the local authority.

Finally, I have demonstrated how public spending cuts since 2010 have impacted on services, with a particular focus on the impact on mental health services (Mental Health Taskforce, 2016; O'Hara, 2013). There is a gap in the academic literature around the impact of austerity on services, and this gap will be addressed by – *thirdly* – researching stakeholder perspectives on how services have been affected, how they are responding to these challenges, and an analysis of how the communities practitioners are working in are

being shaped by austerity. By combining insight from all three approaches I address the identified gaps in the literature, providing an in-depth analysis of the impact of austerity on mental health at a local level. In the next chapter I progress to discuss the methodology used in this PhD, outlining the research strategy I have adopted to explore these issues.

Chapter 3 Methodology

Introduction

In this chapter I outline the methodological approach to my research. The research aims and objectives are presented along with the research design. I then discuss the contrasting epistemological standpoints underpinning qualitative and quantitative research, and give consideration to the debate around mixed methods research. The use of combined approaches is advocated through the adoption of a case study approach and with a critical realist perspective. The research methods I have adopted in this project are then fully discussed. I provide a brief exploration of issues relating to reflexivity, emotion and the role of myself as the researcher, and conclude the chapter with ethical considerations for the project.

Aims and Objectives

The case study has focused on Stockton-on-Tees, in the North East of England. The primary aim of my project was to add to the evidence base around what living in an age of austerity means for mental health and to provide insight into the localised determinants of mental health during this period. I have adopted a critical realist perspective, in that I recognise the structural determinants of mental health, applying a framework that is interested in the mental health consequences of living in inequality and the interplay between structure and agency in the outcomes for mental health. A case study design was chosen because Stockton-on-Tees is such an important case: it has the highest health inequalities in England, for both men and women (Public Health England, 2015). As such exploring inequalities in mental health at this local level – where health inequalities are so high – may reveal greater insight into the determinants of mental health, and the role of

austerity in shaping those determinants. Further, a case study approach would enable an in-depth exploration of inequalities in mental health, using a range of different methods and the ability to triangulate the findings. My key objectives were to explore the differences in mental health between people from the most and least deprived areas, and what is causing these differences. Further, I wanted to look at how austerity is impacting on people who are experiencing mental health problems, what the particular challenges are, and how people are coping with life in this context. As a final strand to the project I was interested in the support that is available to people experiencing mental health problems in Stockton-on-Tees, how services have been affected by, for instance, cuts in public spending, how this impacts on individuals, and how services are responding to this challenge.

For me I was interested in mental health in a broad sense. So I was interested in the differences in people's general mental health and wellbeing between those from different areas of Stockton-on-Tees. However I was also interested in the specific experiences of people who reported having mental health problems in the borough. The evidence base suggests that certain groups of people have been disproportionately affected by the cuts in welfare and public spending, and people experiencing mental health problems fall into this category (Taylor-Gooby, 2012). As such I wanted to explore specifically how this group of people have been affected during the current period of austerity, alongside exploring the gap in general mental health and wellbeing between people from the most and least deprived areas.

My research questions are summarised:

1. Are there inequalities in mental health and wellbeing between people from the most and least deprived neighbourhoods of Stockton on Tees, and what factors are contributing to these inequalities?

2. What are the differences in the lived experiences of austerity for people who have mental health problems in different areas of Stockton-on-Tees?

3. How have mental health and public services in Stockton-on-Tees been affected by austerity and how have they responded to these challenges?

Research Design

Using a case study approach I adopted two research methods to explore these issues: a cross-sectional survey, semi-structured interviews with people who reported having mental health problems, and further semi-structured interviews with key stakeholders. I felt that I needed to use a mixed methods approach because, on a pragmatic level, I felt that this blend of research methods would best answer my research questions. The survey would be able to provide information about inequalities in mental health between a relatively large group of people. It would tell me a lot about structural inequalities in the local authority. It would allow me to explore the relationship between inequalities in mental health and wellbeing and their determinants, looking at which factors were contributing towards the gap. The qualitative interviews would then allow me to unpick what this inequality *means* for people, how it plays out in people's experiences. The interviews with stakeholders would give me a perspective from services, looking at whether different agencies have been affected by the austerity programme and how they have responded to those challenges. Mixed methods would also allow me to triangulate the data, to compare different sources of knowledge and look for continuities and differences.

From a personal standpoint I take a view that social research should look to oppose oppression and promote social justice. As Freire (1970) states: *'Washing one's hands of the conflict between the powerful and the powerless means to side with the powerful, not to be neutral'.* This is in line with Becker (1967), who argued that as researchers it is impossible to

conduct research in a personal or political vacuum, and as such we need to decide whose side to take and whose voices to hear. By researching inequalities in mental health I wanted to explore within the survey how structural inequalities related to people's mental health. People with mental health problems have also historically faced oppression and have often had their voices marginalised (Menzies et al, 2013). The *'hierarchy of credibility'* (Becker, 1967: 241) has meant that preference has often been given to the narratives of people providing the services as opposed to those receiving them. By giving a voice to their experiences within the qualitative interviews, I hoped to give greater authority to their voices and allow their stories to come to the fore.

Qualitative and quantitative research methods have their roots in often conflicting epistemological and ontological considerations. Epistemology refers to '*the question of what is (or should be) regarded as acceptable knowledge*' (Bryman, 2001). Quantitative research is often associated with positivism, a difficult to define term (Marsh, 1982) but an epistemological approach that seeks to apply a scientific model of research to investigations of the social world (Denscombe, 2007). A key assumption is that the social life of people remains independent of human consciousness, and that research should respond to objective experience (Carey, 2009). There is therefore an endeavour to study social processes and phenomenon in the same way as those in the natural world, using the principle of deductivism and the objective gathering of 'facts' (Bryman, 2001). However, 'scientific' methods of investigation often face difficulties in coping with the dynamic and complex social world of human beings (Darlington and Scott, 2002), and qualitative research methods are suited to exploring questions about the ways people view their worlds and create meaning from their experiences (Padgett, 1998). Qualitative research attempts to explore in detail the attitudes, behaviour and experiences of specific social groups (Carey, 2009). Interpretivism is an epistemological framework which attempts to uncover the meaning and 'reality' of people's experiences in the social world, with the researcher trying

to understand the opinions, emotional responses and attitudes articulated by participants (Carey, 2009).

Constructionism is the ontological assumption most dominant within qualitative research. Ontological concerns relate to whether '*social entities can and should be considered objective entities that have a reality external to social actors, or whether they should be understood as a social construct*' (Bryman, 2004:16). Where quantitative methods would understand social phenomena as external facts that can be measured, a constructionist approach would alternatively see social phenomena and their meanings as continually being constructed and revised by social actors, through processes of social interaction (Bryman, 2001).

Mixed methods are a third approach that sit alongside qualitative and quantitative research: Creswell (2014) argues that research practices lie somewhere on the continuum between strictly qualitative and quantitative approaches, and that mixed methods fall in the middle of this continuum, offering a combination of the two. Mixed methods approaches to research have gained in popularity in recent years (Bowling, 2009). The researcher will use a variety of methods to answer the research questions, often using triangulated methods and a mixture of quantitative and qualitative methods in order to improve the validity of the research (Bowling, 2009). There are different ways of undertaking mixed methods research, and Creswell (2014) suggests three general strategies: convergent parallel mixed methods, in which quantitative and qualitative methods are undertaken at roughly the same time and aim to provide a comprehensive analysis of the research problem; explanatory sequential methods, where quantitative results are then explored further with qualitative methods; and exploratory sequential methods, which use qualitative methods to then develop the quantitative strand of the research (Creswell, 2014).

Despite growing in popularity, the adoption of mixed methods strategies has not been without criticism. Some theorists have argued that as quantitative and qualitative methods have such distinct epistemological and ontological roots, their views around how social reality can be studied can never be reconciled. The assumptions, values and methods of each type of research are so conflicting that this makes them incompatible (Bryman, 2001). Smith and Heshusius (2004) have argued this position, asserting that 'method' can be categorised in two ways: as both procedures/techniques (how to do research); and as a 'logic of justification' (underpinning perspectives on the nature of the social world). They argue that confusion between the two has allowed researchers to integrate the two approaches, however that because the 'logic of justification' is so distinct between qualitative and quantitative research, they are ultimately incompatible.

However, the connections with epistemology need to be seen as tendencies rather than absolute connections (Bryman, 2001), and Bryman (2004) further argues that as both qualitative and quantitative research each have their own strengths and weaknesses, this is a convincing argument for combining them. Thyer (2012) also suggests that the two can be combined: '*positivism's contention that there is an objective external reality need not conflict with the position that much of the world of human beings is a social construction*' (in Barbour, 2014: 36). Critical realism has been an attempt to offer an alternative approach that brings both epistemological standpoints into the same fold. Within this approach, social structures are understood as real and their material settings can be researched. However these structures all depend on our relations with them, on the interaction between structure and agency: '*We do not create society… but these structures which pre-exist us are only reproduced or transformed in our everyday activities*' (Bhaskar, 2011: 3).

The use of combined approaches would allow the researcher to explore both structural inequalities and the ways in which people interact with and understand those structures in their everyday experiences. People are seen to have agency to make their own decisions,

however those decisions are made from a structurally generated range of options. Those options are not chosen by people but are infringed upon them (Carter and New, 2004). Higgs et al (2004) argue that it is fundamental to situate health inequality as a product of social structure: critical realist approaches to health allow us to begin from this focus on structural inequalities and expand out to explore how people experience and make sense of these inequalities in their everyday lives. Within my project, a critical realist perspective allows me to combine findings about the impact of structure and agency, and the interaction between the two, on inequalities in mental health. It allows me to explore – on a relatively large scale – inequalities in factors such as income, employment and education, and their relationship with inequalities in mental health and wellbeing. However importantly, the qualitative interviews also allow me to unpick and explore how people understand and interpret these inequalities in their lives, and what they do about them. It means that I can also explore agency, and the interaction between agency and these structural inequalities.

Rationale for the Method

Case study methodology lends itself well to mixed methods approaches in that different methods can be triangulated for the purpose of shedding light on a case from different perspectives (Johansson, 2013). A case study can be either a detailed, intensive analysis of a single case (Bryman, 2001), or a study of multiple cases. It is a useful approach when there is a need to gather an in-depth appreciation of an issue in its natural real life context (Crowe et al, 2011). Traditionally case studies have been associated with qualitative lines of inquiry, although they can also be quantitative, or a mixture of both (Gerring, 2007). Yin (2009: 4) defines the case study in the following way: '*A case study is an empirical inquiry that: investigates a contemporary phenomenon in depth and within its real life context, especially when the boundaries between phenomenon and context are not clearly evident'*. Although one of the prime criticisms of the case study approach lies in questions around generalizability of the findings, Yin (2009) suggests that case studies are generalizable to

theoretical ideas (if not to other populations). The case study approach is appropriate to this study as the local context is so important: Stockton-on-Tees has the highest health inequalities in England (and has a gap that is getting worse) and can be therefore seen as an extreme case. It merits an in-depth exploration of the structures and processes that interplay to create these stark inequalities.

A key advantage to using a case study is that it recognises that there are different ways of knowing a place and of knowing the people in it. The ability to use a mixture of research methods means that I am able to build a picture of the case by looking at it from different angles. This was a strategy employed by Jahoda et al (1972) in 'Marienthal', a classic piece of research into the effects of mass unemployment in a town in Austria during a period of severe recession in the 1930s. The researchers used a mixture of strategies, including both qualitative and quantitative methods, to explore the impact of unemployment on the community (virtually everyone who lived in Marienthal had been previously reliant on employment in the local factory, which had then closed down in 1929). They argued that the '*true position of a distant object can be found only through triangulation, by looking at it from different sides and directions'* (Jahoda et al, 1972: xiv). Their project included a range of techniques, such as accounts of what children took to school in their packed lunches, to explore how the family's economic life revolved around fortnightly payments of unemployment relief. For half of the children in Marienthal, their packed lunches would disappear towards the end of the two week period (as their parents simply couldn't afford to feed them lunch), and then start up again the day after parents received this payment. Novel approaches were blended with techniques such as life histories, food diaries and a range of statistical data. It was through using and bridging together these different approaches that Jahoda et al were able to piece together their 'sociography' of Marienthal, demonstrating the severe effects of unemployment on a small industrial community.

Burawoy also advocates using different techniques to explore a case in the Extended Case Method (Burawoy, 1998). Within this approach, he argues that the researcher begins with theory, building up from the 'micro' level of people's experiences to an analysis of social processes in their wider contexts (Burawoy, 1998: 29). It is the process of continually building and extending on a case, all the while using theory, that gives the researcher greater insight into the research problem. Although critical of positivist methods he argued that they could be incorporated within the extended case method approach, in particular in order to explore social structures. Burawoy positioned his approach as different from grounded theory methodology (as developed by Glaser and Strauss, 1967) and there have been on-going theoretical debates about the merits of each. One of the key differences between them is that whilst the extended case method uses theory as the starting point to the case, grounded theory proposes that we build theory 'from the ground up', with 'the case' being something that is produced in the social world (Tavory and Timmerman, 2009: 243). These differences reflect questions around what a case actually is (e.g. Becker and Ragin, 1992).

My research methodology falls more conceptually into the extended case method approach, because I set out with a theory driven concept of the case (inequalities in mental health in Stockton-on-Tees) and my research involved an on-going process of extending the case. I used two different strategies to explore my research problem: a cross-sectional survey and semi-structured interviews. Theory drove the initial survey and I then incorporated the findings from the survey to develop the qualitative interviews, to explore the case from a different angle and to generate different types of knowledge. This is more in keeping with an explanatory sequential mixed methods strategy (as outlined by Creswell, 2014). After working with the findings from both the survey and the interviews, I then went on to explore services that provide support to people in Stockton-on-Tees, and how those services have been affected by austerity, using the knowledge that had been generated from the first two

approaches to guide that process (outlined in Figure 2).   This dynamic process meant that the project was continually extending. Each method will be discussed in turn.

1. Cross sectional survey exploring inequalities in mental health between most and least deprived areas

2. Qualitative interviews exploring differences in lived experience between people with mental health problems

3. Qualitative interviews with stakeholders exploring services in a period of austerity
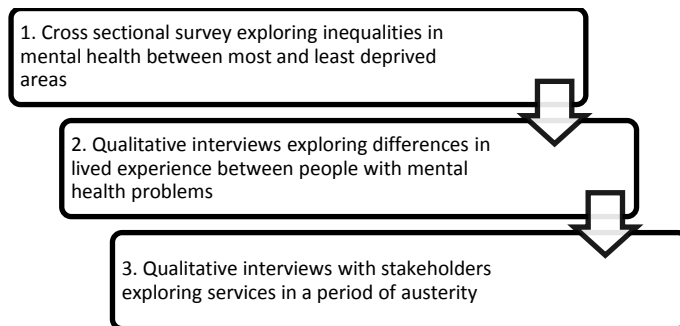
Figure 2 Mixed Methods Research Design

Cross-Sectional Survey

A cross-sectional survey is an approach which collects information about two groups of people at a set point in time, and then compares how much they differ (De Vaus, 1991). This design would enable me to compare inequalities in mental health between people from the most and least deprived areas, and the determinants of this gap. My PhD has been part of a wider prospective cohort study that has followed the same people up over time. However for my project, the time limitations of the PhD restricted the scope for measuring change over a significant enough period of time.   As such I made the pragmatic decision to analyse the baseline findings from the survey as a cross-sectional *snapshot* of inequalities in mental health at a single point in time, addressing the gap in mental health and wellbeing and what was causing this gap, and triangulating those results with the qualitative interviews to explore the impact of austerity on people's everyday lived experiences, and on services. I felt that this would be the best approach to explore my research questions.

A survey can be defined as: '*an inquiry which involves the collection of systematic data across a sample of cases, and the statistical analysis of the results*' (Marsh, 1982: 9).

Fundamental to surveys are their *systematic* nature: participants are asked exactly the same questions, in the same order, and their responses are recorded in the same way. An underlying principle of surveys is that '*the only element of randomness in the survey design comes in the random selection of cases*' (Marsh, 1982: 7). This is to ensure that bias is minimised in any way, for instance with the interviewer affecting responses by asking questions in inconsistent ways, or the changing order of questions affecting how participants respond. It means that the survey is *replicable*. Bryman (2001) introduces three criteria for evaluating research. Alongside replication, *reliability* and *validity* are key concepts that a survey researcher must consider. Reliability relates to whether the results of the study would be repeated if you did the same study again. Validity is concerned with how true the findings are. Construct validity, for instance, is about whether the tool is actually measuring what it says it is measuring. Surveys are usually replicable, whilst questions of reliability and validity will ultimately depend on the quality of the measures that have been used to assess the concepts (Bryman, 2001). In order to avoid these potential issues around validity and reliability, where possible the survey used well-validated measures to assess a range of concepts.

Surveys have their critics. Alongside the epistemological standpoints already outlined, there are also technical considerations. Bateson (1984) suggests that there are good and bad surveys: at every stage in the process the researcher needs to make decisions, and these decisions will ultimately affect the quality of the final survey. A poorly thought through sampling process would jeopardise the whole project. Less disastrous, but still of concern, a badly designed question might lead to systematically biased responses and consequently an inaccurate result. These issues need to be thought through meticulously to ensure that these problems are avoided and minimised. There are some, however, who would argue that these concerns can never be resolved, that surveys create artificial truths that do not reflect the reality of the lives that people are experiencing and that bias may not ever be truly removed (Bryman, 2001).

However a well-designed and well-executed survey gives researchers the ability to produce quantifiable data about a relatively large number of people, allowing them to generalize the findings to the wider population (Bryman, 1988). Surveys can provide information about populations at either one or a series of points in time, and are a key method in the tradition of social investigation. In Britain this tradition was initiated by a will to understand more about the population. The "Bills of Mortality" were introduced in the 1600s with a desire to assess the impact of the plague on the population in London (Marsh, 1982). The first census was completed in 1801. However surveys really developed at the end of the 19th and early 20th Century, and were strongly linked to investigations of poverty and to the nature and problems of the community (e.g. Wells, 1935 in Bateson, 1984). Seebohm Rowntree's study of poverty in York was an early example of this (Marsh, 1982). The use of surveys grew enormously in the post war period and there is now an armoury of nationwide survey research, covering an enormous range of social trends and providing us with a comprehensive picture of society. Whilst recognising that the survey as a method has its flaws, when done well it can provide a detailed picture of society that can help us to understand more about the people living in it.

Sampling Strategy for the Survey

The gap in health between the two areas is examined using a stratified random baseline sample of adults aged over 18, split between participants from the 20 most and 20 least deprived LSOAs. In order to create a sample for the survey the research team used the 2010 Index of Multiple Deprivation (IMD) to identify the 20 most and 20 least deprived LSOAs in Stockton-on-Tees (Dept for Communities and Local Government, 2010). The IMD is a summary measure of relative deprivation for each local authority district, unitary authority and lower layer super output area (LSOA) in England. It is published at the level of LSOA and is formed by pulling together 38 individual indicators that are situated within 7

broader domains: income deprivation; employment deprivation; health deprivation and disability; education, skills, and training deprivation; barriers to housing and services; living environment deprivation; and crime. The IMD provides an overall score by drawing together weighted scores from each of these domains. The scores for each LSOA are then ranked so that there is a relative deprivation score for each LSOA in England. This allows different LSOAs to be compared (Dept for Communities and Local Government, 2011).

The *scale* at which deprivation is studied can have a really significant impact on the results, as different patterns come to the fore with different geographical scales. Using larger areas, such as data at the local authority level, can lead to variations within them being smoothed out. As such it is important to use data at as low a level as possible and LSOAs provide the best means of doing this in England (ONS, 2007). LSOAs are small areas of relatively even size (of around 1500 people in each); there are 32,484 LSOAs in England (Dept for Communities and Local Government, 2011). It is important to be aware however that although the IMD will identify areas that have characteristics that are associated with deprivation, it does not identify *deprived people* (people who could be considered as deprived may be living in an area that is not considered so). It also needs to be seen as a summary measure; IMD scores are made up of weighted individual domain scores and so the summary score does not tell us how each individual domain is scoring. Further exploration of the breakdown of scores would be needed to identify why a particular LSOA has been scored as deprived. However despite this it can be argued that the IMD is an excellent measure to use when exploring relative deprivation (Office for National Statistics, 2007), and as such our project used this tool to identify the 20 most and 20 least deprived LSOAs in Stockton-on-Tees.

Participants were sampled initially by household, and then at the individual level, using a multi-stage sampling strategy (Figure 3). Within this approach, a sample of areas are drawn up (initially larger areas are selected and then progressively smaller ones until a sample of

households are randomly selected within the areas) (De Vaus, 1991). 20,013 eligible addresses were identified from the 40 study LSOAs (the 20 most and 20 least deprived), using the most recent Office for National Statistics postcode lookup tables. The amount of eligible addresses ranged from 313 to 1380 addresses per LSOA (as a result of geographical oddities, some places had very small resident populations). The team randomly sampled (using the simple random sampling technique in the "R" statistical software programme) to produce 200 target households in each of the 40 LSOAs. Subsequently a total of 8000 households (4000 most and least deprived) were sent study invitation letters (200 per LSOA) in April and May 2014. This was in order to assume a response rate of 10%.

Decisions about sample size inevitably involve a compromise between cost and the potential for sampling error: they need to balance how much error the researchers are prepared to tolerate within a sample they can afford (De Vaus, 1991). Although I was treating the survey as cross-sectional, the wider project was a prospective cohort study. Attrition can be a really significant problem within studies that follow the same people over time, as people 'dropping out' can have a cumulative impact on missing data and can lead to severe distortions (Ruspini, 2002). The sample size was based on a conservative power calculation which utilised a range of validated health outcome measures (EQ5D, SF8 PCS, SF8 MCS) and which assumed a 5% difference between the least and most deprived areas, and allowed for a 20% attrition rate between baseline and first follow-up and a further 5% attrition at all other follow ups, giving a final predicted sample size of 400 (200 in each group). A sample of 800 at baseline would ensure that, given attrition, there would be sufficient respondents in the follow-up waves for the wider project to undertake statistical analysis.

In order to avoid bias in the selection of individuals within a household (for instance the person who is not in employment in a household always responding), we followed the

selection procedure that is outlined by De Vaus (1991). Within this, eligible individuals to take part in the study were identified using a selection grid (Appendix B).

Preliminary Work: Survey Development

Within the project team we had regular meetings to develop the questionnaire. There were three of us in the survey team, including myself, the senior researcher on the project, and the project lead. I had an active role in the survey development. There was often debate around questions of validity, of whether questions were appropriate and whether they were phrased correctly. There was also an effort to manage potentially sensitive questions, such

as placing income into category bands and on a show card, asking people which band they were in (as opposed to directly asking people their income).

Oppenheim (1996) suggests that in planning a questionnaire, decisions need to be made about the type of questions to be used (e.g. open/closed/pre-coded categories) and how the questions are clustered together and ordered within the overall questionnaire. There needs to be a consideration of how comfortable participants will feel being asked certain questions at certain points of the survey, and whether one set of questions may then influence how participants answer the next set. Within our team we discussed, for instance, whether there should be more positive questions towards the end of the survey so that the survey would finish on a 'lighter' note. However we decided that the more sensitive questions, such as those around people's health and mental wellbeing, needed to remain towards the end as this would give the respondent and interviewer time to develop a rapport and for the respondent to feel comfortable in answering these questions.

Questions were matched whenever possible to those used in other surveys, to enable national level comparisons to be made, and also to try and ensure a high degree of validity and reliability. Both the physical and mental health outcome measures used were validated instruments. The national survey questions used in the questionnaire are presented in Table 1. The physical and mental health outcome instruments used were the EQ5D, EQ5D-VAS, SF8 and the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). These measures were chosen for their diversity and because they had all been well validated for use in the general population. I will discuss the two instruments incorporating mental health, and their justification for inclusion, later in the chapter.

Table 1: National Survey Questions Used

Survey	Questions Used
Health Survey England 2011	Income scale questions and showcard; marital status questions; national identity and ethnic background; caring responsibilities; if the respondent is cared for by others; social network questions; general health questions; smoking and alcohol questions; physical exercise questions.
General Lifestyle Survey 2010	Accommodation type; residents at the address; transport questions; benefits showcard (although this needed to be amended to include recent welfare changes); monthly outgoings questions; questions about paid work, training/education courses and unpaid voluntary work; educational qualifications show card.
Poverty and Social Exclusion UK 2012	Household features and goods; psycho-social work questions; food poverty question.
English Longitudinal Survey of Ageing 2010	Loneliness questions
European Social Survey 2013	Happiness scale

Questions were revised and amended during the process of developing the questionnaire. This included, for instance, improving questions to make them clearer and less vague, increasing their validity. We took steps to try and ensure that the measures in the survey were measuring what they said they were measuring (that they had construct validity). However, a possible conceptual issue was that all of our data was based on self-reporting. This will always lend itself to questions around whether responses are accurate, in particular from those who do not challenge the '*hierarchy of credibility*' (Becker, 1967). Are people

telling the truth? Do people remember information accurately? However as survey researchers we need to believe that people will respond with honesty, to the best of their ability; otherwise the whole survey method becomes meaningless. By trying to build a good rapport with participants, so that they felt comfortable in taking part in the survey, this would hopefully minimise risks around respondent bias.

The self-reported health measures could similarly lead to the criticism that how people perceive their own health may be different to how their health *actually* is (Subramanian et al, 2009). However there is a strong relationship between self-reported and more objective measures of health (e.g. Kuhn et al, 2006). How people perceive their own health and well-being is also important. For instance with the WEMWBS, it can be argued that it is more credible for a person to rate their *own* mental well-being over the past two weeks than for an external agent to judge that wellbeing on the person's behalf. Researchers should display confidence that respondents themselves have expertise in their own mental wellbeing.

The development of the questionnaire also involved a consideration of what questions were vital for the project and what questions we could possibly afford to lose. Surveys are an expensive endeavour, and as such we were restricted to producing a survey that could be completed with individual respondents within a set time-frame. We were conscious, however, that we only had this one opportunity to do the baseline survey and so it was really important to try to get as much data as possible, within that time span, to explore the gap in health in the borough. At that point we did not know the key variables that were affecting the gap. It was therefore important to try to get as much information as possible to explore the research questions. Different researchers also had some additional priorities of areas that they wanted to explore. For instance, more detailed questions were included in the survey on whether people wished to give up smoking and the reasons behind this. This was a question that I did not then use in my own analysis (I looked at smoking but not at whether people wished to give up), however it was important data for the team, and important data

for exploring health inequalities. This reflects differences in the structure of my PhD: whilst some PhD students are effectively working alone on their research, mine fell within a wider project. This worked really well for me because I enjoyed that aspect of being part of a team, and of my PhD contributing to a wider interdisciplinary exploration of health inequalities in the borough, however it is an important reflective point about the differences that come from doing a PhD that is located within a wider project.

As part of my role in survey design, I had a key role in the questions relating to mental health and mental wellbeing. There were several questions that I designed specifically to fit into my research interests: this included amending the wording on health conditions to explicitly include mental health problems (so that I could identify respondents who reported having mental health problems); amending health service use to explicitly include access to mental health services professionals; and including a question on access to support groups. I was also responsible for selecting the Warwick Edinburgh Mental Well Being Scale as the instrument to measure mental well-being in the survey.

Preliminary Work: Pilot Study

Every aspect of a survey needs to be trialled to see if it works (Oppenheim, 1996), and a pilot study was completed in December 2013 and January 2014 with a sample of 48 households in two 'non-study areas': the 21st most and 21st least deprived LSOAs. These LSOAs were chosen to prevent contamination of the main sampling frame. A letter was drafted and sent out to all of the properties identified.   Some of the properties did not exist and had to be excluded from the sample. We also received a few telephone calls from people opting out of the research. The police were informed of our plan to undertake research in case of any calls from concerned residents. Households who participated were sent a letter of thanks and a £10 high street voucher to thank them for taking part.

We had planned to complete the pilot study in December 2013. During the initial 2 week period we went in pairs to the addresses identified in the sample. We tried to vary the times that we attended the properties to give the best possible chance of catching people at home. The pilot study took place in the weeks leading up to Christmas when the evenings were dark early and people were often busy preparing for the festive period. On reflection this was probably not the best time to try and do a pilot study. Often it was hard to catch people at home. Some people were at home but did not answer the door, especially when it was dark. Others answered the door and arranged a time for us to call back, however were not then at home when we returned. This was, for me, a baptism into the world of survey research, and I found it very frustrating at times. Walking around the streets of Stockton in the cold winter days, unsuccessfully trying to get people to take part, was a new challenge for me. It was always a feeling of joy when a potential respondent agreed to the survey and asked us into the house!

During the 2 week window we did not secure enough respondents for the pilot, and therefore extended the pilot study to January 2014. We sent out a further letter advising people that we would be revisiting their homes to complete the questionnaires. We managed to gather a further few questionnaires in the extended period. Overall the response rates for the pilot were relatively low, at 26% (N=24 addresses) in the 21st least deprived LSOA and 35% (N=24 addresses) in the 21st most deprived LSOA. However the principal aim of the pilot study was to trial the survey and explore how well the questions worked. As such these were sufficient numbers. Despite the challenges highlighted, the positive outcome was that the questionnaire worked well. There were a couple of questions that needed slight amendments. We asked respondents for feedback immediately following the survey. No one in the pilot study felt that any of the questions were too sensitive. This was a good outcome as there had been some prior concerns about the sensitive nature of some of the questions.

Cross-Sectional Survey

A research company was commissioned to undertake the majority of the surveys as the sample was simply too large for myself and the senior researcher on the project to carry out on our own. When surveys are completed by external agents there can be problems that arise as a result of this, for instance in interviewers not asking questions in a standardised way, or not interpreting responses in a standardized manner: different interviewers might interpret the same answer differently (Oppenheim, 1996). Two types of errors can arise from the interviewing process: random errors (resulting from carelessness and inaccuracies) and systematic errors (e.g. consistently asking a question in an incorrect manner). Systematic errors are seen as the most problematic as they could lead to systematic under or over-representation of a true value (Oppenheim, 1996). In order to address possible inconsistencies in the interview process, the lead researcher on the project and I had several meetings with the research company to brief the interview team directly on the questionnaires, how to complete them in the field, and to resolve any queries or misunderstandings about the delivery of the survey.

A letter was sent out to all households selected for the sample, giving full information regarding the survey. Contact telephone numbers and emails were supplied so that households could opt out of the survey or arrange a convenient time for an interviewer to call. Of those who did not respond, the interviewers also attended households to ask potential participants to take part. I was also responsible for completing some of the questionnaires. The initial window for the surveys was a 3 month period between April and June 2014. We did not want the surveys to extend far beyond this period as the time lapse from the beginning to end would have been too great and government policy changes, for instance, may have impacted on the research. The surveys were completed by mid-June 2014.

Analytical Strategy: Data Analysis

The analytical strategy I adopted had several stages. There was an initial sifting process, using bivariate analysis, to remove less important variables from the data analysis. This process involved looking at associations between key variables and the mental health outcomes (WEMWBS, SF8 MCS) (Table 1, Appendix C). 836 participants completed the surveys, however as a result of the data cleaning process (there needed to be a complete dataset for the purpose of analysis), 736 participants remained in the final analysis (this will be explained further in Chapter 4).

Outcome Variables

Two measures were selected to assess mental health in the survey: the Warwick Edinburgh Mental Wellbeing Scale and the SF8 Mental Health Score. The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) is a 14 point scale that considers both hedonic and eudaimonic aspects of well-being and asks respondents to self-report their experience of each of the statements over the past two weeks. It has been well-validated for use in the general population and has moderate to high levels of construct validity (it measures what it says it is measuring) (Tennant et al, 2006). The WEMWBS has 14 statements with 5 possible answers that are scaled from 'none of the time' up to 'all of the time'. The scale gives the individual a total score (up to a maximum of 70); this score is used as the dependent variable and is treated as a continuous variable.

The SF8 instrument provides a measure of physical and mental health and provides a separate score for both physical and mental health. It is a condensed version of the SF36 and has 8 questions; the individual is asked to report how much each question has applied to them over the past 30 days. The shorter SF8 was used as it was felt that although it is

less sensitive than the longer version, on balance it was a more cost effective tool to use within a relatively large survey (Bowling, 2005).

Explanatory Variables

Explanatory variables within the model were separated into four categories: material socioeconomic variables; material physical environment variables; psychosocial variables and behavioural variables. The justification for the use of these variables are discussed in the review of the literature ('Explaining the Social Gradient' p25). I wanted to explore the association between inequalities in mental health and their determinants. In the initial sifting phase of the analysis I therefore used a broad mix of different predictors that fell into the different categories. However there were also practical considerations as a result of the data cleaning process. Frequency of physical exercise could have been analysed using two sources of data: a coded question on how often participants engaged in physical exercise, or a numerical value of how many minutes per week each individual engaged in exercise. As there were 11 missing pieces of data on the latter variable, and none on the former question, it was more practical not to lose those cases from the analysis and use the coded question as a potential predictor instead.

The group of material socioeconomic variables included questions around how the person occupied their home, whether anyone in the household was in receipt of benefits, receipt of housing benefit, whether the participant was in paid employment, whether the household was a workless household, total household income, and highest educational level. The material physical environment variables included questions around living conditions including whether there were problems with damp, with the house being too dark and not warm enough in winter, and also questions around the neighbourhood including problems with crime, pollution/environmental problems, and problems with noise. The psychosocial variables included frequency of meeting socially with friends, family or work colleagues; how

safe the participant felt walking alone after dark; how often the participant felt they lacked companionship; how often the participant felt left out; how often the participant felt isolated from others; and how happy the person would identify as on a scale of 1-10. Finally the behavioural questions included whether the participant smoked, whether the participant drank alcohol, weekly alcohol consumption, daily fruit and vegetable consumption and frequency of physical exercise.

Statistical Analysis of the Data

Within society, individuals exist within complex hierarchical structures (for instance pupils are clustered within schools within towns; individuals are clustered within households within lower super output areas). Multilevel models are an attempt to deal with this hierarchical nature of data (Byrne, 2000; Byrne, 2004) and can be seen as more realistic of the social world we are trying to study, allowing us to incorporate context alongside individuals into analysis (Jones, 2003). Multi-level analysis is linked to the concept of multiple causality, recognising that more than one cause can lead to the same effect (Marsh, 1982). It is based on regression techniques (Ruspini, 2002), in which coefficients demonstrate the strength of relationships between the outcome measure and contributing variables. These relationships can be combined together to produce a composite picture of the different contributing factors (Marsh, 1982). Within my analysis multi-level models were applied to explore the mean gap in mental health between the most and the least deprived areas, controlling for potential clustering between the lower super output areas. Analysis focused on establishing:

(1) The magnitude of inequalities in mental health and mental wellbeing (as measured by WEMWBS and SF8MCS) between the two areas;

(2) The associations between the individual explanatory variables and mental health outcomes; and

(3) The relative explanatory contribution of each of the leading theories of health inequalities (material, psychosocial and behavioural) to the inequality gap.

The analysis focused on the gap in the two mental health scores between respondents from the most and least deprived areas. Multilevel analysis was based on an initial combination of all the significant variables in the initial sifting process. I then applied a model building process to identify the key variables impacting on the gaps in WEMWBS and SF8-MCS. The multilevel models were also used to calculate the percentage contribution of material, psychosocial and behavioural factors to mental health inequalities between the most and least deprived areas. This was to look at the relative contributions of material, psychosocial and behavioural factors to the gap. A similar approach was used by Skalicka et al (2009) in regards to socioeconomic inequalities in health in Norway, and Copeland et al (2015) with respect to the North-South health divide. The reference model for each health outcome is a multilevel model containing only the indicator for the most and least deprived areas together with age and gender, while the adjusted model contained the other explanatory variables that were impacting on the gap in WEMWBS and SF8 MCS.

Once the model building process had identified the final models for both the SF8 and the WEMWBS, separate models were then adjusted for the combined material physical factors, material socioeconomic factors, psychosocial factors and combined behavioural factors, then adjusted for combinations of factors. In total, 11 multi-level models were fitted to the data in order to investigate the relative contribution of each of the factors (material socioeconomic, material physical environment, psychosocial, and behavioural) to mental health inequalities between the most and least deprived areas. This overall data analysis process will be discussed more thoroughly in Chapter 4, when I present the survey findings.

Strengths and Limitations of the Analysis

The survey employed a random sample and featured a comprehensive questionnaire that incorporated multiple validated measures of health and the determinants of health. However the analysis is not without its limitations. The explanatory variables were selected to capture the different determinants of health within the three main theories of health inequalities. For example, the survey questions on psychosocial factors captured domestic, community and workplace aspects of the psychosocial environment, whilst material socioeconomic variables covered factors such as income, education, employment and benefit receipt. Happiness was selected as a potential psychosocial predictor in order to explore the relationship between levels of self-perceived happiness and the mental health outcomes. Although the mental health measures used do not directly ask people to report how happy they are, it is acknowledged that one would expect there may be some association and that one may feasibly impact on the other; happiness is arguably a prominent feature of mental wellbeing (Westerhof and Keyes 2010).

Further, the sample size is only moderate at 836 (although this was assessed as within power for the analysis), with a relatively low response rate. Of those who did take part, the age of respondents was generally older than the general population. Findings therefore need to be interpreted with this in mind as they may not be fully generalizable to the wider population; it is partly a result of who is prepared to engage in survey research. The most and least deprived areas for the study were identified by the Indices of Multiple Deprivation (2010). This is a summary measure of a range of area level deprivation factors. Although the survey focused on individual-level factors, there is some degree of overlap between the criteria for selecting the areas and certain material variables. For instance, the survey asked individual respondents their perception of crime and pollution in the neighbourhood; although these questions were focused at the individual level there is some overlap. This was largely unavoidable as the study was exploring the gap in mental health between the most and least

deprived areas, and the Indices of Multiple Deprivation were identified as the best means through which to identify the sites for analysis.

Finally, this study relates only to one place – Stockton-on-Tees – at one point in time. As this was a cross-sectional analysis, questions arise around the extent to which the results can indicate causal inference. The limitations of cross-sectional regression analysis include: confounding variables, in which variables that have not been measured in the analysis may affect the outcome; and reverse causality, where the outcome variable may impact on the predictor variables (e.g. people with low well-being may take different exercise choices as a result). Many of these factors will be mediators of other factors. Despite these limitations, however, the model was selected as it recognised both the hierarchical nature of the data and best allowed me to consider the strength of the relationships between the different determinants of mental health and the inequality gap.

Semi-Structured Interviews

The participants in the survey who reported having mental health problems, and who consented to be contacted about any potential further interviews, formed the sampling frame of participants to take part in the semi-structured interviews. The case study moved from a consideration of *general* mental health and wellbeing (in the survey), to an analysis of the experiences of people who reported having mental health problems in more and less deprived areas. This is because the literature suggests that people experiencing mental health problems have been disproportionately affected by austerity (Taylor-Gooby, 2012). As such it was important to explore in more depth how people with mental health problems have been affected. The interviews explored inequalities in the lives, and experiences of austerity, between people living in different areas. Although there are clear social gradients in mental health, experiences of mental health problems still exist across the social spectrum

(Marmot et al, 2010). The impact of austerity on people's lives is likely to be different between those from different backgrounds living in neighbourhoods with access to different resources (Bambra, 2016). As this project was focused on the gap in mental health, I therefore focused not only on those with mental health problems from the most deprived areas, but also on the lived experiences of those from less deprived areas, looking at commonalities and differences between people from these different neighbourhoods of Stockton-on-Tees. A sample of participants, mixed between respondents from the most and least deprived areas, were drawn to undertake further interviews, using a theoretical sampling approach, to look at the experiences of austerity for people with a mental health problem. I also developed links with the CAB in Stockton and spent some time shadowing the work of the agency. I recruited some additional participants from the CAB, in order to capture the specific experiences of people who were being supported with welfare advice. I interviewed a total of 17 participants over the course of the research (10 female and 7 male participants).

Rationale for the Method

Within the qualitative methods available, interviews are generally either semi-structured or unstructured. With semi-structured interviews, the interviewer will usually have a list of questions/areas to be covered, although this is followed flexibly. The interviewee has freedom to answer the questions in whichever way s/he chooses, and further questions can be asked or elaborated on. Unstructured interviews, on the other hand, have much less structure. Researchers may adopt this style of interviewing when they are concerned that even a basic interview guide will distort how the interviewees construct the social world around them (Bryman, 2001). Becker and Geer (1957) criticise both types of interviews, arguing that the nature of interviewing means that information is received through a 'distorted lens'. There may be areas the interviewee does not want to, or is not able to, discuss, and the interviewer may not grasp what is actually being said. For Becker and

Geer, participant observation is the preferred qualitative method, as this allows the researcher to become more fully immersed in the social world of the individuals and to develop the *native language*.

Despite these criticisms, however, the interview remains an extensively used research method (Roulston, 2010). It is steeped within the narrative tradition. Narratives can be seen to be made up of four inter-related elements: observational data; the stories participants tell; the stories researchers hear; and the narrative structures that guide the research (Gudmundsdottir, 1996). People tell stories of their experiences, using a narrative structure to organise these. It is the role of the researcher, through a process of interaction, to co-operate with the interviewee to jointly piece together these stories and develop a shared meaning (Mishler 1986 in Gudmundsdottir, 1996). This approach can tell stories of individual experiences, and reveal an understanding of the identities of individuals, how they see themselves and how they construct their understanding of the world around them. This can be an empowering approach because it can enable individuals to '*share their stories, hear their voices, and minimise the power relationships that often exist between a researcher and the participant*" (Cresswell, 2013: 48).

Research Strategy

I chose to use semi-structured interviews because I felt that this was the most suitable method available to explore the stories of how people were experiencing life under austerity in Stockton-on-Tees, what the challenges were and how people coped. The interviews covered the following key areas: personal experiences of welfare reform; narratives around employment/training/education; experiences of mental health support and any changes around this; physical health including its relationship with mental health; sources of social support including family, friends, social networks; leisure; relationship with place (home, the neighbourhood, Stockton-on-Tees); coping strategies. I developed an initial interview

schedule, including information sheet and consent form, for the interviews and completed a pilot study with four participants in August 2014. The main aim of the pilot study was to explore how well the schedule worked, whether there were any emerging themes that were not covered in the schedule, and to receive feedback from participants.

In order to contact potential participants from the survey, I created a new database of respondents who reported having a mental health problem (of any kind). I chose this strategy rather than the alternative of either selecting individuals who had been labelled with certain 'types' of mental health problem, or myself as a researcher attempting to 'diagnose' mental health problems by recruiting participants based on their general mental health scores from the SF8 or WEMWBS. My reason for taking the former approach is that I take a critical perspective of the diagnostic labelling of mental distress. As discussed in the literature review, there is a body of literature criticising the development of diagnostic psychiatry as a dominant approach within mental health (e.g. Horwitz and Wakefield, 2007; Lane, 2007), and I hold the perspective that the specific labels applied to people's experiences are social constructions. I therefore included in the sampling frame all participants who reported having mental health problems of any kind. This meant that the people I ended up interviewing had a broad range of experiences: some participants had substantial involvement with mental health services, including one participant having been detained in hospital against their will; others had received very minimal mental health support.

Within the survey 74 individuals self-reported as having a mental health problem, however 18 of these did not consent to being contacted about any further potential interviews. This left a total of 56 potential participants in the sampling frame (20 in the least deprived areas, 36 in the most deprived). I then telephoned potential participants to discuss the interviews and ask if they would be interested in taking part. Initially there was no real structure to this, I had a list of participants' contact numbers and I tried to make contact with individuals to

see if they were interested in taking part. If they agreed I arranged a convenient time with them and sent out the information sheet (Appendix B) prior to attending the home, in order to give respondents the opportunity to look at the themes I would be covering and to prepare. It also gave respondents the further opportunity to withdraw from the study. Participants who took part were given a £10 shopping voucher as a thank you for their time. I had already met a couple of the participants when I carried out some of the surveys, and this made it much easier to make contact with those same participants to see if they would be interested in taking part. I had already developed a rapport with those participants from meeting them during the survey, and so going back to see them felt more comfortable: both for myself and presumably also them as respondents. In total I interviewed 17 participants for the qualitative interviews: this included 12 participants recruited from the survey (7 from the least deprived areas and 5 from the most deprived), and an additional 5 participants recruited from the CAB.

The pilot interviews had worked very well although there were several further questions/themes I added to the schedule following this and in consideration of the findings emerging from the survey. This is consistent with a semi-structured interviewing approach. Depending on the interview, sometimes I did not follow the schedule, as the conversation flowed in different directions, however it served as a useful reminder to ensure I had followed up all on all of the key themes I had wished to explore. Initially I was anxious about how the interviews would go, whether any of the questions would be too sensitive and whether the interviews would 'flow' well. I was concerned that the subject matter did not increase levels of distress in any way. Although Barbour (2014) argues that when researching potentially upsetting topics, this has the inevitable possibility of being upsetting for participants, for me I was clear that I did not want to cause any unnecessary upset for people, and if something did become upsetting, to provide that opportunity to move the topic into a less upsetting arena (if that was what the interviewee wanted). Researchers need to ask themselves who is benefitting from the research they conduct (Becker, 1967), and whilst

I was trying to cast a spotlight on inequality, and hoped that the research would have a wider impact and would be experienced positively by participants, ultimately it has to be accepted that as a PhD project I was one of the beneficiaries of this project. I therefore felt that causing any unnecessary distress was unacceptable. The semi-structured nature of the interviews helped with this, as it provided that opportunity to move easily to different topics.

I used a voice recorder to record the interviews and fully transcribed and coded these following each interview, to identify emerging themes and concepts to be followed up in further interviews. I also started writing a research journal where I added my thoughts and reflections on the interviews, ideas for further areas to be explore and so on. I interviewed most of the participants in their own homes, although two participants asked to come to the university instead and the interviews took place in an office there. One further participant who I contacted had recently moved away from the area but still wanted to take part, and so I interviewed her over the telephone instead. The interviews took place in a six month period between March and September 2015. The length of interviews generally took one hour, although ranged between 45 minutes and two hours. I used a system to try and ensure personal safety, whereby I gave a colleague the address I was visiting for the interview and asked them to call if I had not been in touch by a set time.

Citizens Advice Bureau

During the course of the fieldwork period I made links with one of the local Citizens Advice Bureaus (CAB) in the area, and was asked if I would like to spend some time shadowing the work of the CAB, potentially to recruit some participants via this service for my interviews. I felt that this would be invaluable in giving me further experience of 'issues on the ground' in Stockton and to be able to more fully immerse myself in the social world I was trying to study, to get a feel for what the issues were for people and a more thorough understanding of the workings of the benefits system. Within the survey we had asked people about

whether they were accessing welfare advice support, as we were interested in what impact this had on people's health and wellbeing, although the numbers accessing it were so small that we were unable to do more thorough statistical analysis. I was interested in exploring the experiences of people who had mental health problems who were accessing welfare advice support, and whether this had a protective impact for people in terms of their mental health. I was also interested to see how people's experiences compared when they were not living in the *most* and *least* deprived lower super output areas. I was interested, for instance, in whether there were differences in experience between people living in relative poverty in the most deprived areas of Stockton (according to the IMD, 2010) compared to those living in areas classed as not so deprived. To explore further whether poverty was the fundamental issue linking those people's experiences together.

I spent a two month period (in March and April 2015) where I attended the CAB once a week, sat in on appointments and spoke to staff about their roles and processes relating to the benefits system. I recruited 5 people to be interviewed via the CAB. Ethically I needed to ensure that my position as a researcher was separated out from the support potential participants were receiving from the CAB, as it was imperative that people did not feel under pressure to agree to an interview because they were receiving help from the CAB. When talking to potential participants I made sure to clarify my role as an external researcher and that this was a completely voluntary process. The information sheet and consent form (the same ones used for interviewees recruited via the survey) also outlined this. I did feel concerned, however, that participants might feel that because they were being helped by the CAB, they needed to agree to do this in return. A couple of people who had agreed to take part in the interviews were not at home when I went to their house at the arranged time to interview them, and I wondered whether this was the result of that process at work. Although frustrating at the time, I was pleased that participants had made that decision and did not carry through with an interview they did not want to take part in.

Being an outsider in the CAB was an interesting time. For the first few weeks I felt very much as one does when starting a new job, anxious about the people and about working out the order of things. I wrote the following note about my first visit:

> *You pass from the waiting room through a door clearly separating the people waiting for help from the hive of activity going on behind the closed doors. There's a warren of offices, the order isn't immediately discernible. Lots of faces; people smile but they're busy working; they move to and fro between the photocopier and their desks, and to rooms I haven't seen yet. I feel unsettled, not knowing the order and not knowing the people.*
> *(Field Notes – 3.3.15)*

Issues can arise from being an external agent working within another agency. At first people seemed unsure of my role and were perhaps more guarded in their responses to me. As a researcher I tried to blend in, not to be obtrusive and to endeavour to see how the organisation worked, to listen to the interactions between the advice workers and get a feel for their perspectives and the issues at play. During the time I spent there people became more used to my presence. I sat in on quite a few appointments where people were helped with filling in assessment forms and compiling tribunal paperwork. This gave me insight into the issues that people face when accessing the CAB and a much better understanding of the work of the agency in the local area.

Sampling, Coding, Analysis

In order to code and analyse the data I used some of the techniques applied by grounded theory and a similar approach as outlined by Strauss (1987). Grounded theory methodology was developed by Glaser and Strauss (1967) and is a style of analysis that has several distinct features. Charmaz (2012:2) argues that it is '*a systematic method of analysing and*

collecting data to develop middle range theories'. Key strategies include coding data from the outset of the research process, use of comparative methods, writing memos, and using a theoretical sampling approach to fill the emergent theoretical categories.

Whilst I used certain grounded theory techniques in my approach I would argue that I did not strictly adhere to this method and followed more closely Burawoy's extended case method, as previously discussed.   Charmaz (2012) suggests that in the coding process most researchers will code for topics and themes, whilst grounded theory codes for processes, actions and meanings. Whilst I asked analytical questions throughout the process (e.g. what does the data suggest?), my coding strategy concentrated more on the emergent themes arising within the interviews. Additionally, although I followed a theoretical sampling approach, I also had some preconceived ideas about the people I wished to interview. Theoretical sampling can be defined as "*a means whereby the analyst decides on analytic grounds what data to collect next and where to find them*" (Strauss, 1987: 38). Instead of a selective sampling technique, in which pre-identified groups are selected for the study (e.g. 50% male, an even age split), with theoretical sampling the researcher will decide on an on-going basis who to interview next, based on the questions, ideas and themes that have been generated from the previous interviews. Whilst emergent themes guided who to interview next and any additional areas to explore, I also primarily wanted to compare differences in experience between people from the most and least deprived parts of Stockton-on-Tees. Subsequently I already had a preconceived sampling strategy, seeking a roughly even split between participants from both areas.

I also had clear findings from the quantitative research to explore further in the interviews; this is more in keeping with the concept of 'extending out', as proposed in the extended case method (Burawoy, 1998). Whilst Charmaz (2012) argues that it is impossible to build theory up without preconceived ideas and theories, at the same time the grounded theory approach (e.g. Strauss, 1978) advocates trying not to impose theoretical ideas and hypotheses on the

data. This was not the case within my research project, as I already had findings that I wished to explore further, compare, and triangulate. As such I would argue that my overall analytical strategy was one of thematic analysis, although I used aspects of grounded theory within this process.

The coding process involved initially an unrestricted coding of the data, line-by-line, that aimed to develop emergent concepts that appeared to fit the data. I then started to fit the open codes into themes. Each interview drew in new themes and ideas, and I followed a process of checking new data against previous data, cross referencing themes and identifying new areas that I might then need to explore further in subsequent interviews, in order to verify a theme or explore that theme from a different angle. The on-going analysis brought in new questions that I then sought to answer by cross-referencing with previous interviews, or in subsequent interviews that I completed.

Grounded theory often points to 'saturation' as the point at which analysis can end. This is a term outlined by Glaser and Strauss (1967) and which suggests that as a researcher you will know when all categories and concepts have been exhausted, and it is at this point, when all avenues have been explored, that the research has reached its end point. However I would agree with Barbour (2014), who argues that this concept of data saturation is not entirely clear. She references Melia's (1997) suggestion that data saturation has a '*somewhat mystical character'* to it (Barbour, 2014: 69). I found it difficult to know at what point to end my period of fieldwork. With some of the themes emerging from the research I was confident that I had generated enough information from the data, but with other areas it would have been possible to carry on exploring other dimensions of a theme, or to take an interview down a slightly divergent angle. It seemed that this process could be endless. On a pragmatic level I was conscious that my PhD was time-limited, and also that I had competing demands from the survey side of my research. For me it was therefore a

balance between gathering enough data from the interviews against the timeline of the project.

Reflexivity, Emotion and the Role of the Researcher

Within qualitative research in particular, reflexivity involves researchers taking steps to understand the role that they themselves have played in the creation of knowledge: this involves the need to carefully monitor the impact of their biases, beliefs, and personal experiences on the research, the "*turning of the researcher lens back onto oneself*" (Berger, 2015: 220). It is about the researcher being actively aware of his/her own position, and the effect this may have on the research process, and taking steps to prevent this from leading to bias or the imposition of the researcher's own experience onto participants. In this section I reflect on some methodological issues relating to reflexivity.

During the interviews I drew on feminist perspectives (e.g. Oakley, 2004) that suggest that the process should be about a conversation; not just giving from the participant and taking from the interviewer. Smith (1987:117) argues: "*If the sociologist just asks questions and the participant responds, this relationship assumes the privileges of her participation in a discourse embedded in relations of ruling*". I wanted to challenge these dynamics within the interviews. I also wanted them to be more of a mutual exchange where possible, and so I also occasionally shared some of my own personal experiences. Although the point of the research was not about my stories, I felt that not doing so would make this very unbalanced. However, it did not always feel appropriate to do this, and there was a continual tension around how much of my own information to share. I did not want to impose my own viewpoints on participants, however I wanted the conversation to be meaningful. In the interviews where I did give more of myself, the interview as a whole often became richer and felt like a more equal conversation. Although making contributions about myself may have added potential bias into the process, I agree with Oakley's criticisms of the need for

objectivity in the interview process, asserting that personal involvement "*is the condition under which people come to know each other, and to admit others into their lives*" (Oakley, 2004: 264). I felt that this was a risk worth taking as it redressed some of the power imbalances within the research, and lent itself to a more natural style of conversation.

It was also important to me that the interviews were not highly structured, and that the participants had more control in dictating the direction and flow of the conversation. I was conscious that participants had given up their time to talk to me and I did not want to be perceived as 'in charge' of the conversation. I also felt that it was important to have a less focused approach than the very structured nature of the survey. As a former social worker, the nature of the assessments that I used to conduct on a regular basis meant that I often had to lead meetings. However as social workers we were trained to try to reduce power imbalances wherever possible (Dominelli, 2002), and in practice it often made me feel uncomfortable that I was in a position of power over the people I worked with. I was also conscious of the power dynamics at play during the survey part of my research; there were often times when a participant would start to chat about topics that were not part of the survey, and in the context of a structured survey these 'asides' were not seen as relevant (although they were relevant to the person). Due to the time demands of the survey (it usually took at least an hour to complete) I often found myself drawing the person back to the structured questions, so that the survey would not take so long that participants might end up getting frustrated with the process.

I wanted to take a different approach with the qualitative interviews, having a set of general themes but allowing the participant to direct the conversation much more and to move into different areas if the participant felt this was important. Power was always present however, and as a researcher it is important to reflect on your own background and how this may exert an influence on the research (Richards and Emslie, 2000); this has been termed 'bracketing' (Barbour, 2014). I faced tensions in the contrast between my position as

researcher and my previous role as a social worker. I at times felt an urge to 'become more of a social worker'. I would find myself thinking of which agencies would be good to signpost an individual to, or I'd be thinking of a problem in terms of how I could help a person to go about fixing it. I needed to reflect on this, and challenge myself, to remain in my assigned role as a researcher.

Finally, the content of the interviews had an emotional impact on me at times. Prior to commencing the research I had made a decision not to ask people why they had difficulties with their mental health. This was because I felt it was too personal a question to ask. However, people generally chose to speak to me about their experiences. These were at times quite hard to listen to. I would describe myself as fairly resilient emotionally however I needed to employ strategies to deal with my own personal emotional response, such as writing a journal note about it.

Stakeholder Interviews

The final stage of the research involved interviewing key stakeholders in Stockton-on-Tees. The aim of these interviews was to build on the findings from the survey and qualitative interviews, exploring from a service perspective how austerity was impacting on Stockton-on-Tees. My key objectives were to explore the range of support available for people experiencing mental distress in the local authority and to explore whether mental health and related services had been affected by spending cuts and funding pressures. I was also keen to identify, from a practitioner point of view, the key issues that were facing people in the local authority, and how services could be improved.

I used a range of strategies to recruit key stakeholders to take part. The wider project that my PhD is part of has a steering committee which meets biannually. This is an opportunity

for key agencies in the local authority to come together with academic staff to discuss the wider research project, network, and share knowledge. I therefore already had several contacts I was able to contact to ask to take part. These people also provided me with additional contacts as a form of snowballing. I also used a website that brings together local advice agencies to access a list of organisations in Stockton-on-Tees. I then contacted several of those agencies to discuss my research and ask if they would be happy to meet with me. Initially I tried emailing agencies, this was a pretty unsuccessful strategy (people generally did not email back!), and so I changed track and telephoned potential interviewees instead. This was more effective, as once I spoke to people and explained my research over the phone, they often expressed an interest in taking part. I had also met one practitioner at a previous event, and used social media to contact him to ask if he would be interested in being interviewed.   In total I interviewed 11 key stakeholders who came from a range of different backgrounds. This included partners in advocacy, welfare advice, the local authority, supported accommodation for homeless people and people with drug and alcohol problems, a mental health drop in centre, psychology partners, and a mental health organisation operating in the local authority.   I tried to gather a range of different perspectives and to look at the breadth of services available for people in the borough. The interviews were conducted and analysed using the same analytical strategy as the qualitative interviews.

Ethical Considerations

Ethical approval for the PhD project was granted by the Department of Geography at Durham University.   Written informed consent was gathered from all participants prior to taking part in both the survey and the qualitative interviews. Participants were provided with a detailed information sheet about the research, a consent form to fill in, and given the opportunity to withdraw from the research at any point (copies of forms in Appendix B). In

respect of the qualitative interviews, I was also concerned that the ability to give consent may have fluctuated. As all of the participants had reported having mental health problems, there was a possibility that some may have been experiencing a crisis at the point of the interview and the ability to give informed consent may have declined. To counter this I rechecked participants' ability to give informed consent to the research at the beginning of the interviews, with the view that they may need to be cancelled/rescheduled if the participant was not in the position to be able to give consent at that point. Participants in the surveys were given a unique identifier number that ensured confidentiality, and participants and stakeholders in the interviews were anonymised with pseudonyms. The right to anonymity was waived by the Director of Public Health in the local authority: there is only one of him in that role, and although he was given the option to be referred to in a different way, he asked to be given his proper title and gave written consent for this. He was, however, given a pseudonym alongside the other stakeholders.

Summary

In this chapter I have presented my methodological approach to my research. I began by outlining my research aims and objectives, before discussing the mixed methods research design and presenting an argument for how qualitative and quantitative methods can be combined. I discussed case studies and the Extended Case Method approach that has informed my design. I then explored in detail the research methods that I used, including the cross-sectional survey and semi-structured interviews. I included some issues of reflexivity, alongside ethical considerations in undertaking the study. In the next chapter I will move on to present the first of the results chapters, exploring the findings from the cross-sectional survey of inequalities in mental health.

Chapter 4 Spatial Divides: Exploring Inequalities in Mental Health and Wellbeing

Introduction

In this chapter I present the findings from the survey, exploring the differences in mental health and wellbeing between participants from the 20 most and 20 least deprived lower super output areas of Stockton-on-Tees. As explained in the methodology section, this survey took place between April and June 2014. 836 participants took part in the survey, split between 397 participants from the most deprived areas and 439 from the least deprived areas. The main analysis of the survey is split into 3 stages, focusing on:

(1) The magnitude of inequalities in mental health and mental wellbeing (as measured by WEMWBS and SF8MCS) between the two areas;

(2) The associations between the individual explanatory variables and mental health outcomes; and

(3) The relative explanatory contribution of each of the leading theories of health inequalities (material, psychosocial and behavioural) to the inequality gap.

I begin the chapter with my initial data analysis and data cleaning process. I then explore the characteristics of the sample, looking at the differences in demographics and key variables between participants from the most and least deprived areas. This considers differences in key variables relating to material, psychosocial and behavioural determinants of mental health and wellbeing. I find key differences between those living in the most and least deprived parts of the local authority. In general participants' lives, and experiences, were often very different dependent on whether they came from the most or least deprived parts of the local authority. This held true for material, psychosocial and behavioural characteristics.

Next I present the multilevel models, presenting firstly the reference model, which explores the gap in mental health and wellbeing between participants from the different areas, controlling for age and gender. I find a significant gap in mental health for both mental health outcome measures. Secondly I explore the key variables that are impacting on mental health and wellbeing in Stockton-on-Tees. This is achieved through a multi-level modelling process. Finally, I present the findings that explore the relative contributions of material, psychosocial and behavioural determinants, to consider which determinants contribute most to the gap in mental health and wellbeing in Stockton-on-Tees. I find that material and psychosocial factors are the key determinants of the gap. I conclude the chapter with a summary of the results and an initial discussion of the survey findings, locating them within the context of the case - Stockton-on-Tees - in a period of austerity.

Data Analysis: Pre-Selection of Variables

The method of data analysis that I adopted involved an initial sifting process to remove less important variables from the data analysis. Initial data analysis involved bivariate analysis looking at associations between key variables and each of the mental health outcomes (WEMWBS, SF8 MCS) (Table 1, Appendix C). I separated the variables into which explanatory factor they fell into within the determinants of health model (e.g. material physical environment, material socioeconomic, psychosocial, behavioural) and then used descriptive statistics and basic statistical analysis (using analysis of variance, t-tests and simple linear regression) to explore whether there was an initial association between the variable and the health outcome. The variables which were not statistically significant ($p<0.25$) in the initial analysis were then excluded from any further analysis (Agresti, 2015; Hosmer et al, 2013).

836 participants completed the surveys, however as a result of the data cleaning process (there needed to be a complete dataset for the purpose of analysis), 736 participants remained in the final analysis. I removed certain cases where there was missing information. Also, certain variables were excluded where there was too much missing data. So, for instance, the questions related to experiences in employment (such as how secure the job is) would have excluded 535 cases from the entire analysis (because the survey had lots of respondents who were not in paid work) and therefore had to be excluded.

Oppenheim (1996) suggests that every survey researcher will need to make difficult decisions about what to do with missing data, and this was one such uncomfortable decision for me. Any strategy to fill the gaps in data involves making inferences about that missing data. As the sample size was large enough I therefore decided not to make any unnecessary inferences. I therefore excluded either missing cases, or, when too many cases from certain variables were missing, entire variables. However some of these decisions were difficult to make. This included the psychosocial work factors. The research base suggests that psychosocial factors relating to the work environment, such as stress and lack of control, may be a key mechanism explaining health inequalities, and as such the need to exclude this information from the analysis was problematic conceptually. However the loss of such a large number of participants from the sample was simply too large for a meaningful investigation of the association between psychosocial work factors and mental health.

Table 2 (Appendix C) demonstrates the cases and variables that were excluded from the final model. Cases with missing data were deleted when these were either: a) a small number; or b) it was felt that on balance the variable was too important to be excluded from the final model. Household income fell into this category, as although keeping the variable meant the need to exclude 71 cases, it was felt that an income related question was too

important to the analysis to lose this, and in pre-selection household income appeared to have a very significant effect (Table 1, Appendix C).

Baseline Characteristics

Following the data cleaning process, 736 participants remained in the final analysis (357 from the most deprived area and 379 from the least deprived). The first stage of the results process involved exploring the baseline characteristics of this sample, looking at general differences between people from the most and least deprived LSOA's and getting an overall feel for the data. This included an exploration of socio-demographic factors, and factors relating to key material, psychosocial and behavioural variables.

The socio-demographic characteristics of the sample are outlined in Table 2. Participants who took part in the survey were older than the general population, with one third of respondents from the least deprived areas, and one quarter from the most deprived areas, over the age of 65. This compares to only 15.6% of the wider population of Stockton-on-Tees being over the age of 65 (Office for National Statistics, 2011). More women than men took part in the survey in both the most and least deprived areas. There were key differences between the two groups in terms of marital status: the majority of participants from the least deprived areas were married (N=223, 58.8%), compared to just over a quarter (N=91, 25.5%) of participants from the most deprived areas. This was also a very white sample, reflecting the characteristics of the wider population of Stockton-on-Tees (93.4% of people from this area are white) (Office for National Statistics, 2011): over 95% of survey participants from each area were from a white British background.

Finally, participants from the most deprived areas were more likely to report having a mental health problem. This is in accordance with the evidence base on social gradients in mental

health (Marmot et al, 2010). 12% of people from the most deprived group reported having a mental health problem such as anxiety or depression when asked about any health conditions they had. This compared to just under 7% of participants from the least deprived areas.

Table 2: Socio-demographic Characteristics of the Sample (after missing data exclusions)

Variables	Number (%)	
	Least Deprived	Most Deprived
Age		
Under 25s	15 (4.0)	37 (10.4)
25-49	131 (34.6)	131 (36.7)
50 to 64	110 (29.0)	95 (26.6)
65 and over	123 (32.5)	94 (26.3)
Gender		
Male	163 (43.0)	147 (41.2)
Female	216 (57.0)	210 (58.8)
Marital Status		
Married	223 (58.8)	91 (25.5)
Single	67 (17.7)	142 (39.8)
Divorced	39 (10.3)	58 (16.2)
Widowed	39 (10.3)	41 (11.5)
Ethnicity		
White	362 (95.5)	341 (95.8)
Asian or Asian British	10 (2.6)	0 (0.0)
Self-Reported Mental Health Problem	26 (6.9)	43 (12.0)

Material Variables

The material characteristics of the sample are separated into socioeconomic variables and those related to the physical environment. They are outlined in Table 3. There were broad differences between the two groups across virtually all of the socioeconomic measures. As expected there were large differences in median net household income bands between participants from both areas (£26000-£28600 for participants from the least deprived areas compared to £10400-£13000 for those from the most deprived areas). This compares to a United Kingdom median household income of £22,880 for the period 2012/3 (Office for National Statistics, 2014).   Participants from the least deprived areas were overall more highly educated: over 25% (N=101) had a higher or first degree, compared to just 5% (N=17) of those from the most deprived areas. Housing tenure trends were also markedly different:

whilst almost three quarters (N=255, 71.4%) of participants from the most deprived areas were renting their homes, the vast majority (87.9%) of participants in the least deprived areas either owned their own home outright or were buying with the help of a mortgage.

As this was a slightly older sample, there were therefore also lots of participants who were not currently in paid employment, many as a result of being past retirement age: 31% (N=112) of those from the most deprived areas were retired, and 38% (N=142) from the least deprived. There were also, however, lots of respondents of working age who were not currently in paid employment, in particular from the more deprived areas where almost half (N=156, 43.7%) of participants were not in employment as a result of being either unemployed, unable to work due to ill-health or disability, or looking after the home/family. Of those participants who did work, those in the least deprived areas were more likely to be in 'professional' roles (11.3% compared to 2.8%), and less likely to be in 'unskilled' jobs.

There were very high numbers of respondents from both areas who were in receipt of some form of benefit. This was because the measure also incorporated the state pension and child benefit. Housing benefit, which is a means tested benefit to provide support with housing costs, was much more prevalent in the most deprived area: 54.3% (N=194) of households in the most deprived areas were in receipt of this benefit.

In relation to the physical environment, participants from the most deprived areas were more likely to report both problems with their housing, and with the wider environment they were living in. For instance, a quarter (26%) of participants in the deprived areas reported problems with damp in the home (compared to 3% from the least deprived areas). Just over a fifth of that group (20.2%) also reported being unable to keep their home warm in the winter. Participants from the most deprived areas were much more likely to report that there was crime in the neighbourhood (29% of respondents compared to just 6% in the least deprived areas), and were also more likely to report problems with noise from neighbours

(24.1% compared to 11.1%), and problems with pollution, grime or environmental problems

(12.9% compared to 3.4%).

Table 3: Characteristics of the Sample: Material Variables

Variables	Number (%)	
	Least Deprived	**Most Deprived**
Socioeconomic		
Highest Educational Level		
Higher or First Degree	101 (26.6)	17 (4.8)
Higher Diplomas/A-Levels or Equivalent	107 (28.2)	39 (10.9)
GCSE or Equiv	87 (23.0)	139 (38.9)
Entry Level/No Formal Qualifications	84 (22.2)	162 (45.4)
Housing Tenure		
Own outright	195 (51.5)	61 (17.1)
Mortgage or loan	138 (36.4)	37 (10.4)
Rent	44 (11.6)	255 (71.4)
Live rent free	2 (0.5)	4 (1.1)
Household Receipt of Benefits	267 (70.4)	312 (87.4)
Household Receipt of Housing Benefit	16 (4.2)	194 (54.3)
Workless Household	143 (37.7)	238 (66.7)
Current Job Skill Type		
Professional	43 (11.3)	10 (2.8)
Unskilled	27 (7.1)	42 (11.8)
Work Status		
Participant in Paid Employment	184 (48.5)	89 (24.9)
Retired	142 (37.5)	112 (31.4)
Unemployed*	53 (14.0)	156 (43.7)
Household Annual Income (Mode)	£36400-£41600	£10400-£13000
Household Annual Income (Median)	£26000-£28600	£10400-£13000
Physical Environment		
Problems with Damp in the Home	10 (2.6)	95 (26.6)
Home is too Dark	31 (8.2)	63 (17.6)
Home is not Warm enough in Winter	27 (7.1)	72 (20.2)
Problems with Neighbourhood Noise	42 (11.1)	86 (24.1)
Problems with Pollution	13 (3.4)	46 (12.9)
Problems with Crime	24 6.3)	105 (9.4)

*'Unemployed incorporates all individuals of working age who are not in employment, including those classed as unemployed, unable to work due to ill-health or disability, or looking after the home/family

Psychosocial and Behavioural Variables

Finally, the psychosocial and behavioural characteristics are reported in Table 4. Of the

psychosocial factors, participants in the most deprived areas were more likely to feel 'very

unsafe' walking alone in their neighbourhood after dark (12.3% compared to 1.6%). They

were also more likely to often lack companionship, feel left out, and feel isolated, than their counterparts in the least deprived areas.

Smoking rates differed significantly between the two areas, with 37% of participants in the deprived areas smoking, compared to 10% in the least deprived. In the wider population of Stockton-on-Tees as a whole, an estimated 20% of adults over the age of 18 are smokers (Public Health England, 2015). Alcohol use was more prevalent in the least deprived areas. Participants from the most deprived areas were slightly more likely to report doing some form of exercise every day (36.1% compared to 29.8%), however were also more likely to report never doing any form of exercise at all (31.7% compared to 25.1%).

Table 4: Characteristics of the Sample: Psychosocial and Behavioural Variables

Variables	Number (%)	
	Least Deprived	Most Deprived
Psychosocial		
Neighbourhood Safety Perception		
Very safe	209 (55.1)	108 (30.3)
Safe	141 (37.2)	132 (37)
Unsafe	23 (6.1)	73 (20.4)
Very unsafe	6 (1.6)	44 (12.3)
Lacking Companionship		
Hardly ever	288 (76)	241 (67.5)
Some of the time	70 (18.5)	76 (21.3)
Often	21 (5.5)	40 (11.2)
Feeling Left Out		
Hardly ever	320 (84.4)	250 (70)
Some of the time	47 (12.4)	66 (18.5)
Often	12 (3.2)	41 (11.5)
Feeling Isolated		
Hardly ever	312 (82.3)	256 (71.7)
Some of the time	54 (14.2)	60 (16.8)
Often	13 (3.4)	41 (11.5)
Behavioural		
Respondents who smoke	39 (10.3)	132 (37)
Respondents who drink alcohol	299 (78.9)	211 (59.1)
Frequency of physical exercise		
Every day	113 (29.8)	129 (36.1)
Most days	65 (17.2)	44 (12.3)
Couple of times a week	79 (20.8)	42 (11.8)
Once a week	14 (3.7)	15 (4.2)
Less than once a week	13 (3.4)	14 (3.9)
Never	95 (25.1)	113 (31.7)

The Magnitude of Inequalities in Mental Health and Mental Wellbeing (as Measured by WEMWBS and SF8MCS) Between the Two Areas

One of the key objectives in this project was to explore the differences in mental health and wellbeing between people from the most and least deprived areas of Stockton-on-Tees. Is there a gap according to where you live, and how big is that gap? Two separate measures were used to assess mental health and wellbeing in the survey: the Warwick Edinburgh Mental Well Being Scale (WEMWBS) and the SF8 Mental Component Score (SF8 MCS). To explore the gap in mental health and wellbeing I firstly looked at the differences in both of these scores between the areas. I began by exploring some descriptive statistics. Boxplots of the differences in mental health outcome scores by area are shown in Figure 4:
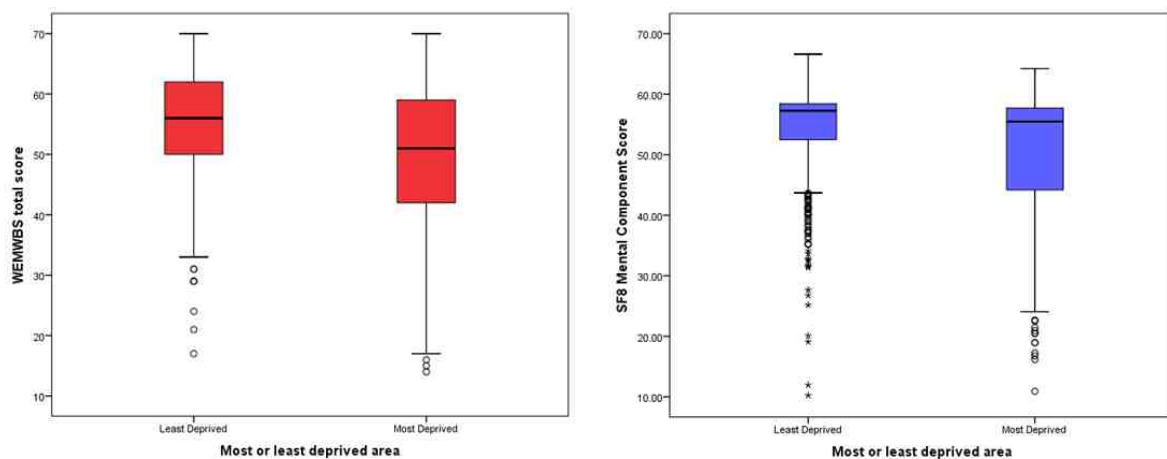
Figure 4: Boxplots of WEMWBS and SF8 MCS by most and least deprived area

The boxplots demonstrate that for both mental health outcomes, there is a larger range of scores for people in the most deprived areas, suggesting greater variation. Lower mental health scores also fell within the interquartile range for participants from the more deprived areas, whereas in the least deprived areas these low scores were so unusual that they became outliers. Median scores were also higher in the least deprived areas (for both mental health measures). This suggests that on average, participants in the least deprived areas scored higher on the mental health measures than their counterparts in the more

deprived areas, and were less likely to have low scores. There was, however, a relatively large range of scores for participants from both groups, suggesting that there is a lot of variation in terms of participants' mental health. Descriptive statistics are displayed in Table 5. These confirm that scores for both mental health outcomes were higher on average for participants from the least deprived areas. The standard deviations were larger in the more deprived areas, confirming a greater variability of scores:

Table 5: Differences in WEMWBS and SF8 MCS between areas

Area		N	Minimum	Maximum	Median	Mean	Std. Deviation
Least Deprived	WEMWBS	379	17	70	56.00	55.17	9.90
Most Deprived	WEMWBS	357	14	70	51.00	50.07	12.21
Least Deprived	SF8 MCS	379	10.24	66.62	57.25	53.61	8.22
Most Deprived	SF8 MCS	357	10.91	64.22	55.48	49.93	11.57

Reference Models: The Gap in SF8-MCS and WEMWBS, Controlled for Age and Gender

Multi-level models were fitted to the data in order to explore the relationship between area and both of the mental health outcomes. The reference models explore the gap in WEMWBS and SF8 MCS between respondents from the most and least deprived areas of Stockton, adjusted for age and gender (Table 6). Age and gender were included a priori to account for the associations between the mental health outcomes and the demographic data. This is important, because age and gender are both known to be associated with mental health (WHO, 2016; Blanchflower and Oswald, 2008). The estimated inequality gap in WEMWBS is 5.04 (3.42, 6.66). The estimated inequality gap in SF8 MCS is 3.80 (2.35, 5.25). This tells us that people have better mental health scores in the least deprived areas when compared to their counterparts in the most deprived areas. On average people from

the least deprived areas are likely to score 5 points higher on the WEMWBS, and 3.8 points

higher on the SF8 MCS.

Table 6: Inequality gap in Stockton-on-Tees for SF8 MCS and WEMWBS: Estimates of Fixed Effects

	Parameter	Estimate	95% Confidence Interval	
			Lower Bound	Upper Bound
SF8	Intercept	50.90	48.59	53.21
	Gender	1.96	0.49	3.44
	Age	-0.04	-0.08	0.01
	Deprivation	3.80	2.35	5.25
WEMWBS	Intercept	49.10	46.52	51.68
	Gender	1.31	-0.33	2.96
	Age	0.01	-0.04	0.05
	Deprivation	5.04	3.42	6.66

The Associations Between the Individual Explanatory Variables and Mental Health Outcomes

The second stage of the modelling process was to explore the key variables that were

impacting on mental health and wellbeing in Stockton-on-Tees. Multi-level models were

fitted for both the SF8 MCS and WEMWBS. The first model included all of the variables that

were pre-selected as being associated with mental health during the initial sifting process

(Table 1, Appendix C). Table 7 highlights all of those variables that were incorporated into

the initial multi-level model, separated by the category of determinant of mental health.

Material factors were separated out between socioeconomic factors and those relating to

the physical environment, to consider the difference between more compositional factors

relating to socioeconomic inequalities, and those relating more to the context in which

people are living, including their home environment and that of their immediate

neighbourhood.

Table 7: List of Predictors by Category of Determinant of Health

Material–Socioeconomic	Material–Physical Environment	Psychosocial	Behavioural
Housing Tenure	Are there problems with damp in the home	How often does the participant meet socially with friends, family or work colleagues	Does the participant smoke
Is anyone in the household in receipt of benefits	Is the home too dark, not enough light	How safe would the participant feel walking alone after dark	Does the participant drink alcohol
Is the household in receipt of housing benefit	Is the household warm enough in winter	How often does the participant feel they lack companionship	Weekly alcohol consumption
Is the participant in paid employment	Are there problems with noise in the neighbourhood	How often does the participant feel left out	Daily portions of fruit and vegetables
Is this a workless household	Is there pollution, grime or environmental problems in the neighbourhood	How often does the participant feel isolated from others	Frequency of physical exercise
Household income	Is there crime in the neighbourhood	Happiness scale	
Highest educational level			

Each model was adjusted for age and gender. The lower super output areas (LSOAs) were treated as random effects in the multi-level models, in order to account for the intra-LSOA correlation. This means that there is likely to be some correlation between participants' scores *within* each Lower Super Output Area (i.e. people within these areas are likely to be more similar to each other than to people in other LSOA's). I used a step by step model building process. Variables that were not significant at $p < 0.500$ were removed from the multi-level model, followed by those that were not significant at $p < 0.200$, then at $p < 0.100$, then those at $p < 0.05$. At each stage of the model reduction, the overall fit of the model was assessed by comparing the reduced model with the previous model to ensure that important

variables had not been lost. This was checked with a sensitivity analysis using likelihood ratio testing (Appendix C shows the calculations for the model building process, including likelihood ratio testing).

Limitations of the Analytical Approach

My modelling approach relied on the assumption that each variable in the model explains some of the inequality gap between the most and least deprived areas. These variables are considered as mediators. Once the relationship between two variables has been established (in this case between area deprivation and the mental health measures), we need to consider the role of other variables in this relationship. Mediators indirectly link the independent variable (area deprivation) to the dependent variable (mental health) (MacKinnon et al, 2000). So, for instance, deprivation impacts on mental health through the mediator of household income. However, this assumption does not hold for every variable within the survey. In the analysis of the WEMWBS there was a suppressor variable in the model (that widened the gap instead of reducing it). Suppressors are variables that hide the relationship between the independent and dependent variable (Conger, 1974). I therefore needed to remove each variable in turn to identify which was acting as the suppressor, and then use the likelihood ratio test to ensure that the model did not lose substantial information by removing this variable (Table 8).

For the variables that acted as suppressors, when any one of them was removed from the analysis, this meant that the other variables did not then act as suppressors. However I could not find a variable that was both a suppressor and where the likelihood ratio test indicated that the variable could be removed. I therefore removed the variable that had the highest p value and was contextually seen as least important for the study. This was how warm the household was. This variable was removed, leaving the final model for the WEMWBS baseline analysis.

Table 8: Identifying the Suppressor Variable in WEMWBS Model

Variable	Outcome
Housing Tenure	Did not act as a suppressor
Happiness Scale	Did not act as a suppressor
Frequency of Exercise	Did not act as a suppressor
Housing Benefit	Acted as a suppressor. Likelihood ratio test p=0.0024
Household Income	Acted as a suppressor Likelihood ratio test p=0.0124
Household Warmth	Acted as a suppressor Likelihood ratio test p=0.04
Pollution	Acted as a suppressor Likelihood ratio test p=0.0189
Feeling Left Out	Acted as a suppressor Likelihood ratio test p<0.001
Alcohol Use	Acted as a suppressor Likelihood ratio test p<0.001

In the SF8 model building process, there were no issues with suppressor variables. However, when the SF8 model was reduced to remove variables that were p>0.05, the likelihood ratio test indicated that I could use the reduced model. However, if I used this model I would have lost a category from the analysis ('material socioeconomic') and also the model would explain less – 90% of the gap in mental health as opposed to 97% - than with that variable kept in. Therefore I rejected the reduced model. It is important to inject contextual knowledge in the model building process because statistical significance (or lack of it) does not always imply the contextual relevance of the results.

The Associations between Explanatory Variables and the Mental Health Outcomes

Table 9 shows the results from the final models used to investigate the associations between the mental health outcomes (WEMWBS and SF8-MCS) and the different material, psychosocial and behavioural factors. These were the key variables that remained in each model following the process of model reduction using likelihood ratio testing.

Only one question on material socioeconomic factors, two questions on material physical environment factors, five questions on psychosocial factors and one behavioural question remained in the final model for the SF8 MCS. People living in polluted areas have lower SF8 MCS scores than those living in non-polluted areas. Also, people living in homes that are too dark have significantly lower mental health scores. A positive significant association was found between happiness and mental wellbeing. Increasing feelings of lacking companionship, isolation and feeling left out were negatively associated with SF8 MCS score. The more unsafe people feel walking alone in the neighbourhood after dark, the lower the mental health score. People that drank alcohol had higher SF8 MCS scores than non-drinkers. Finally, those in paid employment had higher scores than those who were not in employment.

The analysis of WEMWBS shows similar results as the SF8 MCS score for the variables in the models that were important to both mental health outcome measures. People who live in areas where there is grime, environmental problems or pollution have lower wellbeing scores. The happier people feel, the higher their wellbeing score. The more often people feel left out, the lower their wellbeing. The people who drank alcohol had higher wellbeing scores than the non-drinkers. Additionally, for the WEMWBS, compared to people who rent their homes, people who are buying their home with the help of a mortgage have lower wellbeing scores. Those in households that are in receipt of housing benefit have significantly lower WEMWBS scores than those who are not in receipt of housing benefit. Increasing household income was associated with increasing wellbeing. Finally, increasing levels of physical exercise were associated with higher WEMWBS scores.

Intra-LSOA correlation: The random effects results for the SF8 MCS shows that most of the variability in the data is between individual participants, suggesting that there is negligible variation between LSOAs. This would suggest that the data can be treated as independent. However, for the WEMWBS, there is an intra LSOA correlation of $7.29/(64.21+7.29) = 10\%$.

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This means that there is a small amount correlation between LSOAs and the WEMWBS outcome (people within each LSOA are 10% more likely to score similarly on the WEMWBS than those in other areas). The data therefore cannot be treated as independent.

Table 9: Association between mental health outcomes and the explanatory factors based on the variables selected using likelihood ratio test. Point estimates and its associated 95% confidence intervals

Factors	Variables	SF8 MCS	WEMWBS
	Deprivation	.09 (-1.25,1.42)	.07 (-1.64,1.79)
	Age	-.01 (-.05,.03)	.02 (-.02,.06)
	Gender	.77 (-.47,2.01)	-.19 (-1.49,1.10)
Material Socioeconomic	Housing Tenure (Reference Group = people who rent their homes)		
	Own Outright		-1.48 (-3.80,0.82)
	Buy with Mortgage		-3.13 (-5.42,-0.84)*
	Live Rent Free		3.34 (-3.73,10.41)
	Household Income		.23 (.09,.38)*
	Household Housing Benefit (Yes/No)		-3.21 (-5.30,-1.12)*
	Is the Individual in Paid Employment (Yes/No)	1.22 (-.15,2.60)	
Material Physical Environment	The Home is Dark (Yes/No)	-2.58 (-4.35,-.82)*	
	Pollution/Environmental problems (Yes/No)	-2.23 (-4.42,-.04)*	-2.93 (-5.26,-.61)*
Psychosocial	Happiness Scale	1.76 (1.39,2.13)*	2.89(2.51,3.26)*
	Feeling Unsafe Walking Alone after Dark	-.90 (-1.63,-.17)*	
	Frequency of Lacking Companionship	-1.45 (-2.80,-.10)*	
	Frequency of Feeling Isolated from Others	-1.66 (-3.24,-.08)*	
	Frequency of Feeling Left Out	-2.46 (-4.03,-.89)*	-2.93 (-4.11,-1.76)*
Behavioural	Frequency of Physical Exercise		.56 (.25,.87)*
	Alcohol Use (Yes/No)	1.40 (.06,2.73)*	2.82 (1.42,4.23)*
Random Effects	Covariance Parameter	Estimate (Std.Error)	Estimate (Std.Error)
	Residuals	62.85(3.33)	64.21(3.45)
	LSOA	0.04(0.63)	7.29(2.47)

The Relative Explanatory Contribution of Each of the Leading Theories of Health Inequalities to the Inequality Gap

In the third section of the analysis I explore the relative contribution of each of the categories of determinants of health to the gap in mental health and wellbeing in Stockton-on-Tees, looking at which categories are most important relatively in explaining the gap.

Percentage Contribution of each Model to Explaining Inequalities in Mental Health and Wellbeing

To identify how much each model accounted for the gap in mental health outcome scores (in percentage terms), I used the following calculation: 100*(estimate of the gap in mental health in the reference model – estimate of the gap in the full model)/estimate of gap in the reference model. This gave a percentage of how much was explained by each model.

SF8 MCS: For the SF8, the gap in mental health, controlling for age and gender, was 3.80, the estimate for the full model was 0.08. The calculation was therefore: 100*(3.80 - 0.08)/3.80 = 97.76. The full model accounts for **97.76%** of the gap in SF8 MCS.

WEMWBS: The WEMWBS figures were as follows: the reference model estimate of the gap = 5.04; estimate for the full model = 0.07*.* Percentage contribution: 100*(5.04 – 0.07)/5.04 = 98.55*.* The full model accounts for **98.55%** of the gap in WEMWBS

Percentage Contribution of Material, Psychosocial and Behavioural Determinants to Inequalities in Mental Health

The final stage of the modelling process was to identify the percentage contributions of the different determinants of the gap in mental health outcome scores, to explore their relative contribution and to find out which determinants were most important in explaining inequalities in mental health in Stockton-on-Tees. To do this, 11 separate models were fitted to the data, looking at combinations of different categories:

M0 (reference model): Deprivation

M1: Deprivation + Material Physical Environment

M2: Deprivation +Material Socioeconomic

M3: Deprivation + Psychosocial

M4: Deprivation + Behavioural

M5: Deprivation + Behavioural + Psychosocial

M6: Deprivation + Material Socioeconomic + Material Physical Environment

M7: Deprivation + Material Socioeconomic + Material Physical Environment + Behavioural

M8: Deprivation + Material Socioeconomic + Material Physical Environment + Psychosocial

M9: Deprivation + Material Socioeconomic + Behavioural + Psychosocial

M10: Deprivation + Material Physical Environment + Behavioural + Psychosocial

M11 (full model) : Deprivation + Material Socioeconomic + Material Physical Environment + Psychosocial + Behavioural

Table 10 shows the percentage reduction in the inequality gap due to the different categories of mental health determinant. The same calculation as above was used to calculate the percentage change of each model: 100*(Reference Model – Adjusted Model)/Reference Model.

So for instance the percentage change of Model 1 is calculated as 100*(3.80-3.07)/3.80 = 19.13%. By comparing the different models in Table 10, we are then able to estimate the direct and the indirect contribution of the different categories to the inequality gaps. The direct effects refer to the *unique contribution* of each category to explaining the gap in mental health, whilst the indirect effects are the *shared contribution* of the categories in explaining the gap. The direct contribution of each category is worked out by subtracting the percentage change of the model without that category in it from the percentage change of the full model. For example, the direct effect of psychosocial factors to the inequality gap in

SF8 MCS is worked out by subtracting the percentage change of the model without psychosocial variables in it (43.7%) from the total percentage change from the full model (97.76%): 54.06% (i.e. the difference between the percentage reduction of model M11 and model M7).

Table 10: Percentage contribution of material, psychosocial and behavioural models to the inequality gap

Model	SF8 MCS Baseline Causal Model		WEMWBS Baseline Causal Model	
	Estimate	% Change	Estimate	% Change
M0: D	3.80(2.35, 5.25)		5.04(3.42, 6.66)	
M1: D+MP	3.07(1.61, 4.54)	19.13	4.56(2.93, 6.19)	9.48
M2: D+MS	3.02(1.50, 4.54)	20.5	0.87(-1.27, 3.01)	82.79
M3: D+ P	1.06(-0.21, 2.34)	72.01	2.60(1.28, 3.92)	48.43
M4: D+B	3.37(1.89, 4.85)	11.2	4.29(2.67, 5.92)	14.8
M5: D+B+P	0.75(-0.55, 2.04)	80.38	1.91(0.59, 3.23)	62.03
M6: D+MS+MP	2.36(0.83, 3.88)	37.95	0.44 (-1.70,2.58)	91.25
M7: D+MS+MP+B	2.14(0.60, 3.68)	43.7	0.46(-1.66, 2.57)	90.9
M8: D+MS+MP+P	0.27(-1.06, 1.60)	92.85	0.15(-1.59, 1.90)	96.9
M9: D+MS+B+P	0.44(-0.89, 1.78)	88.31	0.30(-1.41, 2.02)	93.99
M10. D+MP+B+P	0.37(-0.93, 1.67)	90.14	1.69(0.36, 3.01)	66.55
M11: D+MS+MP+P+B	0.08(-1.25, 1.42)	97.76	0.07(-1.64, 1.79)	98.55

Using these calculations, the direct contribution of material, psychosocial and behavioural factors to the inequality gap in WEMWBS are 36.51%, 7.61% and 1.61% respectively (Table 11). Among the material factors, socioeconomic factors explained 32% of the health inequality whilst the material physical environment factors explained 4.56%. Material factors contributed the biggest reduction in the estimated inequality gap whilst behavioural factors contributed the least.

The indirect effect of the factors in the WEMWBS is estimated as 52.81%, based on the difference between the total reduction in equality gap from model M11 and the sum of the individual factors contributions (i.e. 98.55 – 36.51 – 7.61 – 1.61). Whilst material

socioeconomic factors contribute the most to inequalities in mental wellbeing in Stockton, there are very high indirect effects. This suggests that the presence of the behavioural and psychosocial factors outlined in the model will aggravate the impact of material factors on the gap in mental wellbeing. So for instance, for an individual who feels unhappy and does not engage in physical exercise regularly, this will exacerbate the impact that being in receipt of housing benefit has on mental wellbeing.

Psychosocial factors appear to contribute most to the gap in SF8 MCS score in Stockton on Tees, at 54.07% of direct effects. Material factors were secondary in importance (17.38%) to psychosocial factors, although there were also still fairly large indirect effects. Behavioural factors had the lowest contribution in both health outcomes (1.61% for WEMWBS and 4.91% for SF8 MCS). Table 11 summarises the direct contribution of each of the category of determinant, and the indirect effect.

Table 11: Percentage contribution of direct and indirect effects WEMWBS and SF8-MCS

Direct Effects	SF8-MCS	WEMWBS
Material (combined)	17.38	36.51
Material Socioeconomic	7.62	32.00
Material Physical Environment	9.45	4.56
Behavioural	4.91	1.61
Psychosocial	54.07	7.61
Indirect Effects	21.71	52.81

Sensitivity Analysis: Model Assumptions

All statistical models rely on assumptions, and multilevel models are no exception. As they are based on regression models the same assumptions apply, however there are caveats within this. The assumptions of *independence (*that outcome values are independent) and of

independent errors (that residuals should not be correlated) are not applicable to multilevel models, because the purpose of a multilevel model is to factor in the *correlation* between cases: they are not fully independent of each other and that is the point (Field, 2007). In my project, individuals are nested within LSOAs; therefore participants from the same LSOAs are likely to be more similar than participants from different lower super output areas. The model accounts for this intra-LSOA correlation by using the LSOA as a random effect in the model.   It therefore does not make sense to test for the assumptions of independence when those assumptions are already violated.

The assumption of *multicollinearity,* which suggests that there should be no perfect linear relationship between two or more predictors, can also an issue if there are interactions that cross levels in the data hierarchy (Field, 2007). Multicollinearity exists when there is a strong correlation between two or more explanatory variables. If they are perfectly correlated, then the value for the outcome measure is interchangeable. Multicollinearity becomes problematic because it is then difficult to assess which explanatory variable is more important in its impact on the dependent variable (Field, 2007).

A further assumption in regression is *normality of residuals* (that residuals should be normally distributed and the mean should be 0).   The residuals are the difference between each data point and the line that best fits the data, representing the amount of error in the model (how far away the model is from the actual data points) (Field, 2007). Gelman and Hills (2007) however argue that the normality of residuals does not affect the parameter estimates in multilevel models. They therefore advise against normality tests because they are not necessary. Box (1976) suggests: '*the statistician knows… that in nature there never was a normal distribution, there never was a straight line, yet with normal and linear assumptions, known to be false, he can often derive results which match, to a useful approximation, those found in the real world*' (Box, 1976: 792). As such he argues that we need to assume a normal and linear distribution whilst knowing these may not hold true, and

with the recognition that the results may subsequently reflect the wider population. On the basis of these arguments I did not therefore conduct further sensitivity analysis of the data, as this was not necessary.

Summary

The results section has sought to explore the inequality gap in mental health and wellbeing between people from the most and least deprived areas of the local authority of Stockton-on-Tees, and what is causing this gap. I have applied a social determinants model, exploring the relative contributions of material (incorporating material physical environment and material socioeconomic), psychosocial and behavioural determinants of mental health and wellbeing. Two outcome measures have been used, the SF8-MCS and the WEMWBS. The results demonstrate that there is a significant gap for both of these measures; this gap is slightly more pronounced in the WEMWBS. Living in less deprived areas affords considerable protection towards general mental health and mental wellbeing, and people who live in these areas are likely to score significantly higher on mental health measures.

This is consistent with the substantial research base evidencing inequalities in mental health (Marmot, 2010). Consistent associations have been found between poor mental health and low income; low education; low social status; unemployment; and poorer material circumstances (Melzer et al 2004). The literature suggests that it is not only individual factors (such as having a higher income or better housing) that impacts on the relationship between living in a more affluent area and better mental health, but also the context of the area itself which could be protective. This includes such things as the physical environment (e.g. there is better access to green space in more affluent areas), opportunity structures (e.g. better access to healthcare services or education or childcare), or the economic environment (e.g. availability of better jobs) (Bambra, 2016).

The research has also shown that material and psychosocial factors are the most important determinants driving the divide in mental health and wellbeing in Stockton on Tees. However, there was a difference between the two mental health measures in terms of which category had the biggest direct effect on the outcome. With the SF8 score, psychosocial factors contributed most to the gap (54%), whereas in the WEMWBS it was material factors that took precedence (37%). Psychosocial variables such as social isolation were particularly important in the SF8. Participants in the most deprived areas, who tended to be slightly younger, seemed more isolated and lacking in companionship than those in the least deprived areas. This was an interesting finding because social isolation is a problem that is most often associated with the mental health of older people (Cattan et al, 2005). As such, the findings suggest that either deprivation is strongly associated with social isolation in addition to the impact of age, or that the older participants in the most deprived areas were feeling so much more isolated than their counterparts in the least deprived.

There was some overlap in the final variables left within the two models; pollution was important for both mental health measures, alongside alcohol use, how often the individual felt left out, and the self-reported happiness measure. Although happiness as a concept is not measured in the WEMWBS, one would expect there may be some association between the happiness scale as a predictor and mental wellbeing as an outcome: in our understanding of wellbeing, happiness is a feature of emotional wellbeing (Westerhof and Keyes 2010). As such there may have been some correlation between them.

Where factors such as household income and receipt of housing benefit were crucial in the WEMWBS, these material factors became less important in the SF8 and were replaced with (of the socioeconomic factors) whether the individual was in paid employment. Being in employment was not as strongly associated with the SF8 MCS as the socioeconomic factors were to the WEMWBS: the association was only significant at p<0.100. It was kept in the

model, however, as removing it would have meant the loss of the entire category of socioeconomic factors from the model. Finally, for the WEMWBS, I found that compared to people who rented their homes, people who were buying their home with the help of a mortgage had lower wellbeing scores. Although some of the housing literature describes home owners as having higher wellbeing in contrast to renters (e.g. Filakti and Fox, 1995), most likely because it is a marker of income and wealth, in the UK home ownership is a large heterogeneous sector (Searle et al, 2009). As such owner occupiers exhibit an uneven health profile (Smith et al, 2004). The findings reflect this diversity, suggesting that home ownership can be problematic for mental wellbeing.   Home ownership can also be precarious, and this may be a factor that increases the potential risks to mental health.

It can be argued that the SF8 may be a less robust measure than the WEMWBS. The SF8 is a condensed version of the SF-36. The SF-36 is a measure of 8 health concepts that cover: physical functioning; role limitations because of physical health problems; bodily pain; social functioning; general mental health (mental distress and mental wellbeing); role limitations because of emotional problems; vitality (energy/fatigue); general health perceptions. The shorter SF8 covers the same health concepts but uses single item questions for each category as opposed to several (Ware and Sherbourne, 1992). Whilst the shorter SF8 scale reduces the burden on respondent and interviewer, and is a more cost-effective scale to use within a larger survey, it also carries the downside of being less sensitive and of being prone to distortion from bias (Bowling, 2005). There are only three questions that relate to mental health in the SF8, compared to the 14 in the WEMWBS; as such the latter scale may be a more precise tool.

Another possible reason for the divergence lies in the scales themselves; they are measuring slightly different things and were chosen for the study because they were different. The WEMWBS covers both eudemonic and hedonic aspects of wellbeing. These relate to feeling good (hedonic well-being) and functioning effectively (eudemonic wellbeing).

Whilst feeling good involves aspects such as interest in life, confidence and engagement, functioning effectively is about having a sense of purpose, feeling in control of life, and the ability to create positive relationships (Huppert, 2009). Whilst the WEMWBS scale covers both eudemonic and hedonic functioning, the SF8 seems to have a greater focus on issues related to functioning – role limitations because of emotional problems, and the ability to get involved in social activities. The SF8 also asks people to rate their general mental health, which the WEMWBS does not. The scales therefore differ in what they are measuring, and as such this may be why their determinants have differed.

The third possibility is that both material and psychosocial factors are key in explaining the gap in mental health and mental wellbeing between people from more and less deprived areas during austerity. The statistical analysis shows that there are very large indirect effects in the WEMWBS (53%), and smaller, although still substantial, indirect effects in the SF8 (21%). This suggests that those different factors are working together in determining outcomes. Having a low income, and living in an area that is deprived and may have problems with pollution for instance, can make people unhappy, unwell, and can prevent people from being able to engage in activities that can make them feel included in life and connected with others. It is the combination and shared contribution of factors such as these, working alongside each other, that have a cumulative impact on mental health and can seriously undermine people's wellbeing. Within psychosocial models of health inequalities, it is on-going, chronic levels of stress that ultimately exert an impact on the body, leading to physical and mental ill-health (Brunner and Marmot, 2006). It is not difficult to see how living in poverty, with all of the challenges that this brings to people, can lead to chronic stress.

The research has identified that behavioural indicators are the least important of the categories determining the inequality gap in mental health and wellbeing. This is true for both of the mental health measures that I used. This is important, as much public health

activity focused on reducing health inequalities tends to lean towards behavioural interventions and individual behaviour change. This shift towards a focus on the individual has been labelled as 'lifestyle drift' (Hunter et al, 2009: 3). Increasing physical activity is a much-used piece of advice given to people to improve their mental wellbeing (e.g NHS, 2014a), alongside 'eating healthy' and drinking less alcohol as a means to combat depression (NHS, 2014b). Although behavioural factors such as exercise play a role in mental health and wellbeing, they seem to have a far smaller direct impact than either structurally based material factors or psychosocial components. The participants in the study who drank alcohol actually had better mental health scores than the non-drinkers, although this may have been related to people abstaining from alcohol use as a result of physical health problems. It may have also been related to the context in which participants consumed alcohol: meeting up with friends in a pub may, for some, serve as a protective factor because of the added social benefits incurred from this, including reduced levels of social isolation.

It does, however, need to be recognised that the study used general measures of mental health and wellbeing. It may be the case that the determinants of more clinical indicators of poor mental health may differ from the determinants of general mental health and wellbeing identified in this study. There is, for instance, a strong link between alcohol consumption, depression, and suicide (WHO and Calouste Gulbenkian Foundation, 2014). Within the model, weekly alcohol consumption (in units) 'dropped out' of the model relatively early as it was not significant. However it is possible that the small number of the heaviest drinkers in the sample may have had different mental health scores to the overall sample.   Despite the evidence that some of the determinants of general mental health and wellbeing may differ from the determinants of more clinical indicators, socioeconomic factors appear to have comparable effects on both mental wellbeing and reported mental health problems (Huppert, 2009). This suggests that there may be some overlap between the determinants of general mental health and more clinical indicators, such as incidence of mental health problems.

The findings need to be placed in the context of the UK programme of austerity measures, and how those measures have impacted on inequalities in mental health. Previous international research has shown that where welfare services are cut, this leads to increasing inequalities in mortality and morbidity: whilst overall population health is generally unaffected, cuts in welfare have a detrimental impact on the health of the poorest people in the population (Krieger et al, 2008; Blakely et al, 2008; Shaw et al, 2005). Across England there has been an increase in indicators of poor mental health since 2010, and evidence nationally of widening inequalities in mental health (Barr et al, 2015). Whilst population mental health usually declines during an economic recession and then recovers, this has not been the case in the current period. Mental health continues to be affected, including an increase in rates of suicides, with 2013 witnessing the highest male suicide rate since 2001 (Office for National Statistics, 2015c). The largest increases in poor mental health (including suicides, self-reported mental health problems and anti-depressant prescription rates) have been in the most deprived areas, leading to increasing spatial inequalities in mental health (Barr et al, 2015b).

The survey findings cannot demonstrate temporal changes during the period of austerity, because of their cross-sectional design. However they do lend support to the argument that socioeconomic factors play a significant role in driving inequalities in mental health and mental wellbeing at a localised level. If austerity-related measures are increasing social inequality in the borough, this has clear implications for inequalities in mental health. There are already substantial inequalities between people from the most and least deprived areas of the local authority, and as such, any increase in deprivation amongst the poorest (for example as a result of welfare cuts) may further impact on these inequalities. Health profiles of Stockton-on-Tees have identified that since 2010, the life expectancy gap between the most and least deprived areas has worsened in the local authority (Public Health England, 2015). This would suggest that health inequalities have indeed grown since the onset of

austerity. As health and social inequalities are so intimately connected, this would suggest that social inequality has also worsened.

In conclusion, this chapter has presented the findings from the cross-sectional survey, in which I have provided a comprehensive analysis of local inequalities in mental health and wellbeing in Stockton-on-Tees. I have found that there is a significant gap in mental health and wellbeing between people who live in the most and least deprived areas of the local authority. This gap in mental health reflects the health inequalities overall which are known to exist in Stockton-on-Tees (Public Health England, 2015). I have explored the key factors impacting on mental health and wellbeing in the local authority, evidencing a range of factors that contribute towards people's overall mental health. These include socioeconomic factors relating to income, housing and the environment, connectedness and a sense of belonging, and 'healthy living' determinants such as the frequency of exercise. These factors work together and interact in people's lives to have an overall impact on their mental health.

In my analysis I have found that material and psychosocial factors are the most important determinants of the gap in mental health. Whilst behavioural factors are often privileged in the public health literature, in this analysis I have found that these are the least important components. It is more important, to feel mentally well, to have a reasonable level of income, to live in neighbourhoods free from environmental problems, to feel safe and to feel a connection with other people. As an overarching finding, the results have shown us the high degree of social and spatial inequality in Stockton-on-Tees: it is these structural inequalities which are significant contributors to inequalities in mental health and wellbeing. The findings provide a local context for understanding inequalities in mental health and well-being, and their social determinants. Whilst there is a body of research lending support to material, psychosocial and behavioural determinants of health (Marmot and Wilkinson, 2006), this is the first known UK study to statistically examine the relative contribution of these determinants to the gap in mental health and wellbeing. The findings show that in the

local authority with the highest health inequalities in England, material and psychosocial factors are significant drivers of inequalities in mental health and well-being. This is in line with the view that poverty, with all of the material and psychosocial challenges it brings, acts as a constraint for many of the conditions needed to live a decent life (Shaw et al, 2006), and provides a local context to the wider literature showing the links between socioeconomic and spatial inequalities and health (Bartley, 2008; Marmot et al, 2010). There are still disputes about the precise mechanisms which contribute towards health inequalities, and this analysis adds to the literature by demonstrating the importance of factors such as income, the environment, and social connectedness. However it has also identified significant indirect effects, which suggests that the factors identified in this analysis are combining with each other to have a cumulative impact on mental health and well-being. This suggests the need for a multi-faceted understanding of the determinants of mental health at the local level, which incorporates these different factors and recognises the complexity that exists in people's lives.

This chapter has shone a light on inequalities in Stockton-on-Tees and how people's lives are very different in different parts of the local authority. However the survey data can only tell us so much. It tells us overall trends and is very effective at revealing material inequalities such as income and employment, within the population. However, although able to identify key variables that are impacting on mental health, the survey is unable to go into more depth about those factors. Having a low income has an important negative impact on mental health, but what does that *mean* for people? What does struggling financially look like in someone's life, and what impact does it have on them? And how does having enough income have a protective impact? People have agency so how do they respond to these inequalities? For my research project, the next step was to look at how people *experience* these structural inequalities. Moving on from a consideration of general mental health and wellbeing, I wanted to extend the case by exploring the experiences of people who reported having mental health problems in different parts of the local authority. What does it mean to

live with mental health problems in a more deprived area compared to an affluent one? How are people's lives different, and/or their experiences shared? How are austerity, and the welfare cuts, shaping lives? In the next chapter I will move on to the present the results from those qualitative interviews. In this way I begin to unpick what these inequalities mean to people and how they play out in their everyday lives.

Chapter 5 Deprived Times? Contrasting Lives and Experiences

Introduction

In this first of the qualitative chapters I present the results from the qualitative semi-structured interviews, in which 17 participants were interviewed: 7 from the least deprived areas, 5 from the most deprived, and 5 participants recruited from the Citizens Advice Bureau (CAB). The participants had often faced very difficult experiences in their lives. In particular with those recruited from the most deprived areas and the CAB, participants discussed multiple issues. These impacted on each other and compounded the problems that participants were facing in their day-to-day lives. These issues often interweaved with each other, and a key point of this chapter is that dealing with complex *multiple* issues made life very challenging for some of the participants in the study. So, some were not just dealing with mental health problems, they also faced the challenge of managing on a reduced income, of being unable to work, increased chronic stress as a result of welfare cuts. Although participants were surviving they were faced with numerous challenges in their lives. Austerity measures such as the welfare cuts were exacerbating this situation for those on low incomes, making life even more challenging for a group of people who were already dealing with a lot of issues in their lives.

The first section explores the role of structural factors and the impact of worsening material inequalities on participants' lives. Participants' experiences of the impact of austerity on their day to day lives are discussed. Section two explores themes relating to power dynamics and the ways in which people coped with a lack of power. Throughout the chapter there is a consideration of the similarities and differences in experience between people from the most and least deprived areas, and those from the CAB. Whilst participants from all of the groups had experienced difficulties with their mental health, and had some overlap in experience, their lives, and the challenges they faced, were often very different. This had an impact on

their mental health and on the strategies they used to navigate this. There was not always a neat symmetry, however, between the issues people faced and the areas they lived in: people's lives are very complex and this diversity was reflected in the interviews.

Divided Lives: Structural Inequalities and the Impact on Mental Health

This section explores the role of material factors in differences in experience between people from the most and least deprived areas. There were sharp differences between participants from the least deprived areas, and those from the most deprived areas and CAB (the latter two groups had very similar experiences and in many ways could be combined into the same group). A central theme was that for the participants from the most deprived areas, their material circumstances were worsening as a result of austerity measures.

The Daily Struggle

> *You're living week to week. Food's gone mad, gas has gone mad, electric has gone mad.* (Jimmy, 47)

Money worries were an issue for many participants who were recruited from the most deprived areas. This follows on from the survey findings, in which income was strongly associated with mental health and wellbeing. Jimmy, above, used the term 'mad' to reflect on the increasing costs of living and that sense of a loss of control in being able to manage the family's finances. Participants talked about the stresses of struggling financially, of worrying about how they would pay bills, of how they would be able to cope. The participants who were recruited from the CAB were in a similar position to those from the most deprived areas and presented with similar narratives in relation to their finances (that of

struggling). Claire lived with her husband and worked part time in a local community centre. She spoke of her difficulties in managing the costs of daily living:

I think it's still bad, like bills and that, they've gone up a hell of a lot… it's absolutely horrendous... Your money doesn't go as far as it used to. And the wages don't go up much to compensate. I think it's definitely harder, we're struggling. (Claire, 49)

An analysis of income and poverty in the United Kingdom between 2010 and 2015 identified that for people at the lower end of the income scale, there is a growing group of people whose material circumstances are significantly worse than they were 5 years ago. Increases in the cost of living (including the cost of food, fuel and rent) are having a greater impact on overall finances, as these items make up a growing percentage of expenditure (MacInnes et al, 2015). These findings were reflected in the interviews. Paul lived with his girlfriend and they were both currently out of work. He described how their income was not enough to meet their basic needs:

It's not enough to live on. Cause we get, what, a hundred and forty a fortnight, for the two of us to live on, and that's nothing… It makes you anxious thinking how am I going to live, how am I going to afford this. (Paul, 27)

The participants who were employed in low-paid jobs were really struggling to manage financially. Participants who were in receipt of either Job Seekers Allowance (JSA), or Employment and Support Allowance (ESA), or had been affected by welfare changes such as the bedroom tax, appeared to be in some of the most precarious financial situations. Laura had been affected by the bedroom tax and a new requirement to pay council tax (following the abolition of council tax relief). This was having a significant impact on the family's finances. Laura discussed how these changes were having an impact on her ability

to keep her house warm. Her experiences place her in the same position as 9% of families across the UK who are unable to adequately heat their home (PSE UK, 2013):

I never used to pay bedroom tax, but now I pay £15 a week, plus we pay £22 poll tax…I mean, fifteen pound a week. To pay the rent. In the winter, it's like a battle, because these houses are really cold. So we can only afford to heat one room, which is this one [living room]*. We can't afford to heat our bedroom, radiators cost, they are expensive to run. And you just don't have the money to do it. So mainly we live in the one room. (*Laura, 53)

There have been several 'symbols of austerity' that have arisen in the wake of 2010: these have included the rise in food banks in the UK (O-Hara, 2013). In research at a food bank in Stockton-on-Tees, linked to the wider project this PhD is part of, Garthwaite et al (2015) explored the challenges faced by people who accessed food banks. They found that people often had health problems that were exacerbated by poverty and food insecurity. Food consumption followed a cyclical nature: people would run out of money towards the end of a payment period, and the quality of food would suffer until they were paid. Whilst the participants in this study had not accessed food banks, many discussed food as one outgoing in which they would try to make savings. Participants talked about going without, or buying cheaper food, to ensure that they were still able to pay their bills. Jimmy talked about the cyclical nature of food consumption, and how the family had to rely on food that was less nutritious because it was within budget:

I wouldn't say there's nowt in my fridge but there's nothing like, of any nutrition. So if anything suffers, I pay my bills, but we don't eat brilliant. You know, beans, hot dogs, toast. Even just a simple piece of meat, beef, well that's kind of money spent better elsewhere. So you find yourself categorising things. So as long as

you've got a bit of food in the cupboard. But that works on a fortnightly basis,

you know what I mean. (Jimmy, 47)

Managing Comfortably: Financial Stability in the Least Deprived Areas

In contrast to the challenging financial situations of participants in the most deprived areas, those in the least deprived areas were on the whole comfortable financially: they did not present as worrying about money and saw the 'cost of living' as either something they had not considered or something that was now improving. Finances were not an issue that came up naturally in the interviews with these participants (whereas for the CAB participants, and those from the most deprived areas, issues relating to income were very often discussed unsolicited). Jen commented:

I'm one of the lucky ones. I can just go out, and this sounds awfully like you're

bragging and I'm not, basically we can buy what we want, you know. (Jen, 62)

These participants did not see themselves as being particularly affluent but felt that they had enough to maintain a decent standard of living. This is perhaps reflective of living costs being a smaller percentage of expenditure for this group in comparison to those on a low income (where fluctuations in costs would have a far greater impact). Dennis, who had taken early retirement from the Civil Service, spoke of how he felt that the cost of living had improved recently:

I've found in recent months the petrol is down, and that's had a knock on effect

on gas and electricity, and I've found that gas and electricity is cheaper than it

was maybe two years ago. So I think it's quite cheap now, inflation is next to

nothing anyway. So yeah I find it very comfortable. (Dennis, 57)

Most of the participants from the least deprived areas came initially from more working-class backgrounds, however had gone into careers within the public sector (e.g. police officer, job centre advisor), bought property when it was relatively inexpensive to do so, and had fairly comfortable incomes. Jen, who was now in her sixties and recently retired, spoke of her upbringing in a working class background:

I was born near Holy Trinity Church, in Stockton, and then we moved to Middlesbrough, because me dad got made manager of this tyre place... Me mam and dad were never well off, money was always an issue. We never went without, but there was no room for luxuries. I think we only ever had two holidays. (Jen, 62)

Jen went on to describe meeting her husband and how they bought their first home. They were now in a position where they were living mortgage free in one of the least deprived areas of Stockton:

We got a council flat, and I says, 'How about thinking of saving for a deposit for a house?' Because Jim's from a council estate background, and you know, people didn't buy. I always remember me mam saying 'Buying's not for us'. Not realising that they couldn't afford it. So we saved up, and this house was 18 and a half thousand pound. And we put two and a half thousand pound on it. (Jen, 62)

There were a small number of participants who were exceptions to the general picture of people in the most deprived areas struggling financially, and those in the least deprived areas being relatively comfortable. This reflects the fact that participants from the most and least deprived areas were drawn from the survey, and that the Indices of Multiple Deprivation (which were used to identify the most and least deprived LSOAs for the survey)

are measures of place deprivation (as opposed to identifying people who are deprived). One such participant was Mandy, who lived in one of the least deprived areas. She had previously been employed in a high paid role however was made redundant when the financial crisis hit, subsequently found another job, however during a period of serious ill-health and a mental health crisis in which she was detained in hospital involuntarily, she was made redundant from that role and had been unable to find work since. Her financial situation was very precarious and she was on the brink of losing her home:

> *I've had to use all my savings, because you're only allowed so much in savings before you get your Job Seekers Allowance. I should be semi-retired by now. I'm 54, and I was a real career high flyer, and now I've had to cash in all my endowments and everything. I've had to sell my car. So times are going to get really tough for me. I don't get housing benefit because it's my own house, I get so much towards my mortgage but it's not enough to pay my mortgage, so at the moment I'm just really, really applying for jobs.* (Mandy, 54)

'They're playing god with you': The Consequences of the Benefits System

For those participants who were living on a low income, a recurrent theme when they talked about lack of money was stress. Not having enough money was described as being stressful. The stress involved in not having enough money was particularly present for those who were reliant on benefits, and was linked to the concept of uncertainty, of not knowing when/if benefits were going to be paid and of the worry about how to make ends meet if they weren't. Participants talked about this being a relentless, on-going level of stress that they had to deal with, and how when one benefit was stopped, this often had a knock on effect on other benefits. This relentlessness led to chronic stress, which often aggravated the difficulties that people were already having with their mental health. Jimmy talked about being under a relentless pressure since 2010:

The minute the Conservative government came in, there was no let up. With the

pressure. Four years. I worked it out the other day, so in that four year, well it's

a blur to me really. Cause I'm still enduring it. (Jimmy, 47)

Stress was also talked about in relation to Employment and Support Allowance (ESA) and the Work Capability Assessment (WCA). The WCA is a tool which assesses people for their eligibility for ESA, a benefit that has replaced Incapacity Benefit. Previous claimants and any new claimants are assessed via the WCA. People can also be reassessed at intervals to identify if they are still eligible for the benefit. The WCA has come under heavy criticism in recent years, with arguments that the process is not fit for purpose: nearly 40% of appeals lead to decisions being overturned (Barr et al, 2015a). Mental health charities have led calls that the process is damaging people's mental health (e.g. Mind, 2012), concerns that have been backed up by recent academic research finding an association between reassessments via the WCA and an increase in suicides, self-reported mental health problems and prescriptions in anti-depressant use (Barr et al, 2015a).

Debra was facing an upcoming reassessment for ESA and had been informed that she would be being taken off it and would need to appeal. She discussed how this worry was impacting on her mental health:

I'm terrified. It's absolutely eating me up. How the hell am I going to manage?
Because they'll automatically put me on Job Seekers Allowance. How on earth
am I going to manage? If I start thinking about it I'll end up in tears. And shaking.
It has brought on some dreadful panic attacks thinking about this coming up.
(Debra, 55)

Participants who were (or had been) in receipt of ESA talked overwhelmingly about this as an on-going, *revolving door* process of failing medicals, appealing, passing appeals and then being reassessed within a very short space of time. This was a constant process; even when participants had passed an appeal it was only a matter of time before a letter arrived requesting a reassessment. Some participants kept going with the appeals (particularly those who were being supported by the CAB), whereas others had given up and gone onto JSA. Lily talked about the continuing levels of uncertainty and how she attributed this stress to leading to her drinking alcohol again after a long period of abstinence:

> *They keep taking me off Employment and Support Allowance and putting me on Jobseekers, saying that I'm capable of work. I've had three medicals with ATOS and got 0 points. Went to the CAB and they sorted it out and I got 15 points. It's just changed again… I don't know whether I'm coming or going. When I'm going to get paid. If I'm going to get paid… You just feel like you're repeating yourself, repeating yourself. It's a nightmare. (Lily, 60)*

One of the key ways in which the benefits system aggravated the difficulties participants were experiencing with their mental health was through increased levels of stress. This included being mandated to attend courses or certain activities, such as the Work Programme, as a requirement of receipt of benefits. This was often very challenging for participants who were struggling with their mental health and who had difficulties dealing with the pressure of these situations. Jimmy had been on the Work Programme, which he was mandated to attend as a condition of receiving ESA. Jimmy reflected on the difficulties involved in this and the impact on his mental health:

> *I've just been on a two year work programme, which was compulsory, but I used to turn up and my brain would be elsewhere, in a terrible state. And that just finished in January, I had two year of that. And that was like pressure that I just*

didn't need. Of turning in.   I'm all anxious and stressed and going in different

environments that I'm not used to. (Jimmy, 47)

Increasing conditionality has been one of the key features of the "welfare reform" programme, and has included an increase in sanctioning. Under this process, claimants can be refused benefits for periods at a time when they do not comply with rules relating to job-seeking (O'Hara, 2013). There was a stark rise in the numbers of JSA sanctions given between 2010 and 2014, with over 800,000 applied in that period (Lupton, 2015). Effectively sanctioning leaves people without an income, forcing people into financial hardship. Andy talked about suicides in his local neighbourhood and attributed this to the rise in benefit sanctions and the impact of this on the mental health of the whole community.

I think nine people in the last few months have jumped in that river, local people.
Out of all of them, I think one was an accident. All the rest, it's just that bad
around here… People aren't coping. (Andy, 46)

In 2013, the suicide rate in the UK was at a 13 year high, with the region most affected being the North-East (Office for National Statistics, 2015). This increase in suicides has been linked in part to the severity of welfare cuts (Barr et al, 2015b).

Financial Struggles: Ways of Trying to Cope with a Lack of Money

The participants who were struggling financially adopted a variety of methods and strategies to cope with this. Many of these strategies involved 'doing without'. Patrick (2015) highlights findings from a study of the lived experiences of welfare cuts, in which managing on benefits involved strategies such as shopping in the reduced aisles in supermarkets, 'shopping around', and pawning items in difficult times. Similar findings are presented here. As has been discussed, food often suffered as people did without decent nutrition in order to ensure

that bills were paid. Some participants also talked about going without so that their children did not have to; this supports evidence that parents will often try to protect their children from the worst extremes of poverty (Main and Bradshaw, 2016). Jimmy, who lived with his wife and two children, talked about how he would ensure that his children had their needs met:

Don't get me wrong, my kids have an Xbox, but they had an Xbox like three years after the Xbox came out. So my kids have never wanted for anything because I just don't buy anything for myself… They're the sacrifices that you make, you make the sacrifices for your children. (Jimmy, 47)

Laura talked about needing to shop around for the best buys on groceries. This was different from how she previously managed her budgeting, when she was able to buy most of her groceries from the same shop:

You're always, like, looking for the cheapest shop really. Where once over you could think I'll just go to Asda and do me shopping there, you can't now. Cause you think, a loaf of bread in here's £1.50, I could go to Aldi and get two loaves for that price. So you're like dropping between shops, you know. (Laura, 53)

Participants also spoke of using catalogues as this meant that, although more expensive in the long run, they could spread the cost of more expensive household goods into more manageable weekly payments. Participants did not have savings that they could rely on in the event of needing to buy relatively expensive items, such as white goods. Alison talked about the strategies she would use:

My brother helps, he'd sort of get it and then I'd pay him when I get it. But failing that it's a case of get it on the never never. I say that but it's catalogue, my friend's got a catalogue. (Alison, 50)

At times participants would rely on informal networks. Debra spoke about how her neighbour had helped her out with a repair, and how she in turn then exchanged the favour:

> *He's just saved me a fortune on the washer. My washer broke, and it turned out to be the filter. He had it in bits, spent the whole day doing the washer. So, you know, I don't begrudge drying his clothes for him in the winter. He saved me the cost of the washer.* (Debra, 55)

However despite these strategies, and careful budgeting of finances, participants also spoke of how there simply wasn't enough consistently to get by. Paul discussed these challenges:

> *It is hard, because when you're thinking of the electric you can't think 'I'll put this on that', because you never know how much you're going to use. And you try and keep some back, but then you run out of something like food and you've got to dip into that, and then the leccie runs out and… so you're just going round and round.* (Paul, 27)

The Employment Divide: Work, Health and Mental Health

There is a wealth of evidence suggesting that being out of work negatively affects health and leads to worsening mental health (Bambra, 2011). Insecure, poor quality employment is also a risk factor for mental health (WHO and Calouste Gulbenkian Foundation, 2014): insecure employment can be as damaging to health as unemployment (Kim and Knesebeck, 2015). Participants from the most deprived areas and the CAB generally had employment trajectories of insecure, low paid work. Although the majority of these participants were not in paid employment at the time of the interviews, none of them fitted into dominant neoliberal stereotypes of being part of an 'underclass' who had never worked. Participants had lengthy

employment histories and wanted to be in work if they were able (some, as a result of their physical and mental ill-health, were not able to work).   Paul spoke about his extensive employment history:

> *Me first job was a paper round… after that, I went to college. Me next job was B&Q, I was on the tills about a year and a half, I worked in the garden department… I worked for Bells, and I worked at Zanzibar, one of the nightclubs. It's now closed down. I cleaned for Middlesbrough council… I used to be a youth worker… I had that job for about six months before government cuts and stuff closed it down.* (Paul, 27)

Claire was still in part time employment at a community centre, although as a result of her deteriorating health she was unsure how long she'd be able to stay in work. Clare had stopped working for a period when her children were young in order to care for them. She spoke about the shop and production jobs she'd had in the past and the insecurity of those roles:

> *I've done a lot of shop work, filling shelves, on the till. I've worked at the crisp factory. I've worked at Frankie D's, it's not that now, it's Sainsburys… I've worked at Tescos as well. I didn't work for a lot of years because of my children. I had no one to mind them… I was made redundant from Tescos, that was why I left there. I liked that job but it closed down and I lost my job.* (Claire, 49)

Clare had then trained to become a teaching assistant however the lack of permanent jobs meant that she was unable to continue in that career. She talked about the difficulties of being employed by an agency:

I was working for an agency, and they were reluctant to take you on because of money. So I was shoved all over the place. And they were putting me further and further away, and you were supposed to get paid for your bus fares but only so much. I had to get a taxi to one, cause' it was the other side of Middlesbrough and I couldn't get to it by bus. But they were messing me about... I couldn't get a permanent job and like I say, I started at the community centre. (Clare, 49)

As in other studies, for participants who were not able to work as a result of ill-health or disability, they spoke about their illness or disability as determining their relationship with the labour market (e.g. Pemberton et al, 2016). Their employment histories often involved unskilled or manual work. For the participants who had developed physical health problems, this had meant that they were often then unable to continue in previous roles when their health problems had become too severe (e.g. labourer). Lily had previously been a care worker for severely disabled people. She had loved her job however her physical health problems had impacted on her ability to work and she had to leave. Lily developed lumbar spondylosis, which is degeneration in the spine. This was very painful and Lily was on the waiting list for operations to her neck and back. Lily spoke of having to leave employment:

The last project, when I was finished, were two old gentleman in Hartlepool. Both with severe epilepsy. But you see, when they had seizures, you don't just stand there and watch them have the seizure. You get down, and if I get down I can't get back up again, so what good would I be. So, you know, that was the end of my career. (Lily, 60)

The participants who had significant physical health problems spoke of how these interacted with their mental health. These narratives were more present in participants from the more deprived areas. Participants spoke about their health being cyclical (about having 'good'

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days and 'bad' days). When their physical health was bad, this often impacted on their mental health, and vice versa: the one would aggravate the other. Coping with chronic pain appeared to have a particularly detrimental impact. Claire was living with significant pain on a daily basis as a result of fibromyalgia. Although she was still working part-time, she was concerned about how long she would be able to remain in her current role due to her deteriorating health. She described the interaction with her mental health and how she was affected by the pain:

> *I get depressed, bit worse now because of the fibromyalgia. I think it's because I am coping with the pain. It all came to a head and I thought I can't go on like this. I didn't want to go on because of the pain and that, I thought I can't cope. I had a bit of a breakdown and I went to the doctors and he put me on the amitriptyline, just one then, to block some of the pain. It does affect me a lot. The depression has been brought on again because of this.* (Claire, 49)

Alongside health problems preventing some participants from being able to continue in their previous roles, work itself had also caused physical ill-health for some participants. Jimmy spoke about his previous role as a manual labourer. This had led to chronic back problems; over time this led to a more acute injury that prevented Jimmy from being able to continue in that job:

> *I used to be a raw material handler in a plastic factory. We used to lift like 25 kilo bags, tons and tons of them, and pallets. I started to get troubled with my back, my hip. Like a sciatica pain.* (Jimmy, 47)

The development of physical health problems had also led to experiences of loss for a lot of participants: alongside the loss of the ability to work in previous employment, they spoke about the loss of independence and of former roles such as being able to play with children

or to manage the housework in the home. This had an impact on participants' self-identity. Peter spoke about the rupture between his previous sense of self and how he sees himself now:

> *In my eyes, before my crash, I was fit, I was moving steel around, moving rolls of paper around, probably like 3 tonnes. And it seems such a shock to me, my arms are skinny, it seems weird not to be fit and healthy.* (Peter, 47)

Some participants discussed the lack of suitable jobs to apply for. The lack of employment opportunities is borne out by the data. Job density profiles for 2014 showed there were 0.73 jobs per working age resident in the local authority, meaning that there were not enough jobs for the number of people looking for them (Nomis, 2015).   The participants who were not in employment missed working and wanted to be in work, discussing the social benefits of working, doing something they felt was 'productive', and the benefit of having more income. Paul discussed how he missed the financial freedom that working had given him:

> *I enjoyed getting up, going to work, coming home, having me tea. End of the month, a thousand pound or so, paid the rent, paid tax and stuff, and I was still coming out with like six or seven hundred pound a month… It's more freedom.* (Paul, 27)

He went on to describe the contrast financially between being in and out of work, and how it impacted on his mental health:

> *Nowadays, it's like, you're on the dole, being on the dole it's like a lifestyle, and it's a big come-down from work. It's a big shock to the system. When you're depressed and things like that, and you lose your job, it makes you anxious*

thinking how am I going to live, how am I going to afford this, and, that's another

thing that doesn't help with depression and that either. (Paul, 27)

Participants in the least deprived areas generally reported more secure employment histories, for instance with long careers in the public sector. James, who came from a working class background, described his initial employment history after leaving school:

Having that work ethic from me dad, and that council estate upbringing, I'd do

anything. I did loads of jobs, worked in shops, worked for friends, did gardening

jobs, went down to London for a bit on a building site. And then I worked with

severely disabled kids, at this college. (James, 47)

After a year working with disabled children, James was subsequently recruited by the police, and has remained in the police force for almost thirty years:

The metropolitan police were recruiting all over the country…I saw the girl from

the met in the job centre, it was about 1986… She said 'Come down to

London'… So I went, did 5 years down there. I transferred back up here in

1992… And that was it, I bounced around doing different jobs in the police, and

then went into the CID type role in 1998... And I've been pretty much doing that

since then. (James, 47)

Although these participants generally reported more secure employment histories, some also reported increasing job insecurity, increasing pressures, and changing demands at work. These were talked about as a significant source of stress. For this group of people, austerity was particularly experienced in terms of its impact on the working environment. Employment was an area in which participants saw an impact of austerity related measures

such as reduced budgets and increased workloads. Dennis discussed how austerity had impacted on his work at HMRC:

In 2010 you had the austerity. We had the austerity as well. So the money was cut, the expectations of bringing more money in was increased, and the training was pulled back… and that's the environment you're working in. So I felt like I was treading in sand. And it just meant you were going into work every day thinking 'God this is hard work'. And it was all throughout the office... It was horrible, absolutely horrible. (Dennis, 57)

Psychosocial factors relating to working environments have all been shown to be damaging to mental health (e.g. Brunner and Marmot, 2006). As participants in the interviews were generally older, they were often able to report on changing demands at work over a period of many years in the same agency. Employment was cited more often as impacting on mental health for participants in the least deprived areas (for participants in the most deprived areas, employment appeared to have a greater impact on their physical as opposed to mental health). Brenda talked about her changing role at work, initially the DHSS which then merged into Job Centre Plus:

I used to work for the benefits side of things, the helping caring side of it, you know, making sure that people's benefits were there, not all about finding people jobs. But then they did the merger a few years ago, so I jumped before I got pushed. I went into Job Centre because I could have ended up anywhere... I've done it for too long. The job's changed so much. You get the impression that you're not there to help people any more, you're there to do a business. (Brenda, 56)

Despite increasing demands and job insecurity, the participants in the least deprived areas nevertheless had notably more job security than their counterparts in the most deprived areas, with the majority having remained in the same employment over periods of many years.

The Difference Place Makes: Mental Health and Home

Everyone's got their own different opinions of it and that but to me, it's where I was born and it's where I live, it's where I grew up. To me it's home. (Paul, 27)

Most participants (from all groups) had very strong ties to Stockton-on-Tees, having been born there and lived in the borough for most, if not all, of their lives. As a result they gave a sense of belonging to Stockton and to their communities. In the least deprived areas, most participants had lived in the same home for a long time; apart from one participant they all owned their home (either buying it with the help of a mortgage or owning it outright). There was more fluctuation in the more deprived areas and with the participants from the CAB: some participants had lived in the property a long time whilst others had moved in relatively recently. Most participants in these two groups were renting their current home.

A key theme that emerged was around the concept of the home as an *asylum*. Many participants (from all groups) spoke about how, during periods where their mental and physical health was particularly bad, they would physically retreat into the safety of the home. In contrast to public health guidance suggesting that people should get out more and engage more socially to improve their mental health (e.g. NHS 2014a), for a lot of the participants the opposite was true during a period of crisis: they felt they needed to be away from other people until they started feeling a bit better. Staying at home seemed to be a strategy that people used to keep themselves safe and to ride out the worst of a difficult

time: participants talked about shutting down, going to sleep, closing the curtains and 'seeing through' a period of distress. Avoiding the outside world was a coping strategy:

> *I just used to put meself in bed, and sleep. I could sleep for days. I knew, if I'm asleep, I don't have to deal with reality, with what's going on. So I would just sleep and sleep. I would wake up and go to the toilet and get a drink of water and just go back to bed. I would lose literally a stone doing that.* (James, 47)

For the participants in the study who were in receipt of out-of-work benefits, the intrusion into their home of the benefit system, in the form of regular letters notifying them about changes such as reassessments and appeals decisions, meant that this concept of the 'home as an asylum' was broken. It was not a space where participants could shut out the outside world, because the benefits system intruded into that space. Additionally, the physical environment of the home had an added impact. Several participants in the most deprived group were living in homes that were in a very poor condition. Paul, who was in the process of applying to move, spoke of the problems with his flat:

> *It's getting worse. The windows are knackered. It's like damp and stuff on the floor so we've had to pull all the carpet up, that's why there's no carpet. The flat itself, when there's loads of traffic, it shakes. It vibrates for about half an hour. It's horrible, absolutely horrible.* (Paul, 27)

Some aspects of the physical environment where people live are potentially damaging to mental health (Curtis, 2010). This was a theme in which there was a difference between participants from the most deprived areas and those who had been recruited via the CAB (who generally lived in relatively deprived areas however did not live in the *most* deprived LSOAs of the local authority). Whilst some participants from the CAB discussed occasional problems with their home and neighbourhood, generally they perceived the streets they lived

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on as being relatively safe spaces. The concern around neighbourhood safety was cited as important by many participants in the interviews (regardless of whether they came from the most or least deprived areas) and also feeds into more psychosocial models of the determinants of mental health (e.g. Marmot and Wilkinson, 2006): people wanted to live in places that felt safe, both for themselves and for their families. The reason for feeling positive (or negative) about the home environment often concerned how safe it was perceived to be:

> It's a nice quiet area. And it's good for the kids, because the kids can all play out the front and there's always some mum have got their eye on them all. (Alison, 50)

However in the most deprived areas, participants talked more frequently about social problems, in particular about difficulties of living in proximity to drug and alcohol abuse, problems with noise, and crime.   Paul talked about the lack of safe green spaces in the neighbourhood for his family:

> When the bairn's here, she's like 'Can I go and play out?' Like, the little park bit around there, we only allow her to stay there, cause there's too many smackheads, in the block of flats, alcoholics and that, so we don't like her going on the field… The amount of needles we've found on that field. We don't want the bairn going over there, like falling, and pricking herself on one of them. (Paul, 27)

These problems with the social environment could at times have a significant impact on participants' mental health.   Debra talked about problems with her previous next door neighbour, who was a heavy cocaine user, and how the noise from parties had a chronic impact on her mental health:

It was a nightmare. We'd got parties going on, cocaine dealers next door. The party would start on Friday teatime and it would finish on Sunday night… She was outside here one Sunday screaming her head off at her boyfriend. I phoned the landlord, I said 'Will you ring next door?' I said 'This has been going on now since Friday teatime, I can't stand any more, I'm going to have a breakdown'. (Debra, 55)

Despite difficulties with social problems in the neighbourhood, participants still however generally had ties to their communities and saw their neighbourhoods as home. Participants from the deprived areas (and from the CAB), who had lived in Stockton-on-Tees for most of their lives, had often lived in the same ward for their entire life. Their own personal identity was connected with the place they lived and had grown up in. Places can be seen to have specific identities, made up of a history, a geography, industry and culture, and these *'biographies of place'* (Warren and Garthwaite, 2014) were at times reflected in the personal biographies of participants. Laura spoke of the changing geography and culture of the neighbourhood she came from:

I was brought up on Norton Grange. And then got married, moved around a bit, but always in Norton. Been in here about eight year now… Me mam and dad always lived in Norton. So did [her husband's] parents. So we've always, like, been in Norton… The community is not like it was years ago. I think the redevelopment put a stop to all that. Because they built another load of houses where they'd knocked a load down. Where they should have just gone in and modernized and left the community there. But they didn't. People just went here, there and everywhere. (Laura, 53)

The environmental and social problems that were present for people in the deprived areas were largely absent in the narratives of participants from the least deprived areas. They lived in areas that they perceived as relatively safe, where crime was not a significant problem, where they had enough space that they did not have to deal with noise from neighbours. Although some spoke of how the sense of community wasn't 'what it once was', there was no sense of the physical environment having a damaging impact on participants' mental health. Jen had lived in Eaglescliffe, one of the least deprived areas, for over 30 years. She described the area:

It's a nice area really, there's the odd break-ins, but there's no trouble with kids. There's some nice shops, there's a nice bakers… it's a nice area. We've got the train station within walking distance, we've got the airport. It's noted round here for being quite affluent. (Jen, 62)

The 'therapeutic landscapes' literature discusses the potentially beneficial impact of certain natural environments on mental health, such as access to woodland or the coast (e.g Curtis, 2010; Cairns-Nagi and Bambra, 2013). For some participants, aesthetic landscapes were discussed as being important for their mental health. Catherine talked about the aesthetic reasons for buying her current home:

I chose the house because I loved the street, there were all the trees and there was the green space at the end of the road, and a big tree, and I thought 'this is very nice'. (Catherine, 58)

James had lived in Ingleby Barwick, one of the least deprived areas, for just over 15 years with his wife and daughter. He talked about the area and reflected on how, although it was safe, affordable, and met the family's needs, he would have preferred to live somewhere more attractive:

We moved to Ingleby Barwick. The houses are cheaper over there so that's why we've stayed. It's not ideal but it does. It's just, you know, soulless. Thousands of brand new houses, just stacked up on top of each other, so it's not like an olde worlde place with lots of character about it. It's just a brand new housing estate. It's dry and it's warm and it serves its purpose. And it's cheap enough. And there's no crime up there really. And the kids are alright. (James, 47)

James went on to discuss his ideal home, in the countryside in North Yorkshire:

I'd like a static caravan, maybe in Swainby… the views are stunning. You come out on your veranda with a cup of tea on a morning and there's like rabbits, and deer and stuff, no traffic, no horrible people. I could probably see meself finishing up in one of them, checking out of society, sat there on my meditation cushion with my incense sticks and my little Buddha. Grow old out there. (James, 47)

For James, as with some (although not all) of the other participants, access to green spaces, woodland and 'therapeutic landscapes' were reflected on as being important for their mental health. However although these participants were living in some of the least deprived areas of the local authority, they generally spoke of having to travel to benefit from more therapeutic environments. The home environment, for participants in the least deprived areas, was beneficial because it did not have those features of deprived environments, such as crime, which could have such a detrimental impact on living in the most deprived areas.

Life Events and their Significance

Life had been pretty good and from like a swerve ball out the side, things started going wrong. All over the shop. People dying, family dying, cancer, dogs dying, houses getting burgled, all sorts of stuff. Splitting up with me missus. It culminated in a 12 month period, I'd never had depression before, never experienced it. (James, 47)

It is important to acknowledge the contributory role that other experiences played in people's narratives around their mental health. Alongside the structural inequalities that have been outlined in this chapter, participants (from all groups) also highlighted the importance of other experiences – such as abuse, grief, and loss – they had faced in their lives. These events had caused significant distress. For those who were dealing with poverty, factors such as worsening financial situations and relentless benefits assessments served to compound these issues, creating additional levels of strain in people's lives. The accounts of people from the CAB and from the most deprived areas often included reports of traumatic experiences such as domestic violence or of abuse. These accounts of violence were generally gendered: all of the reports of domestic violence were described by female participants, although one male participant described experiences of childhood abuse. Claire spoke about how witnessing domestic violence as a child had a lasting impact on her mental health. She had spoken to her mother about the impact domestic violence had on her:

A lot of me depression and that comes from me childhood. Things would flare up, me dad used to beat my mam up. [As an adult] *I was going to North Tees seeing the psychiatrist and psychologist, and one day when I'd come back from the hospital and I was upset and that, me mam said 'Every time you go to the hospital to sort it out, you're worse'. And she said 'Why are you going?' And I*

said 'Because of me dad and everything'. She broke down my mam, she said

'Oh my god I wish I'd left him'. She blamed herself. (Claire, 49)

Claire was still trying to deal with the effects of the domestic violence on her mental health. However alongside this, she also faced other significant challenges in her daily life, such as chronic physical health problems, financial worries, and concern that she would soon have to give up work because of her health. These added significant additional stress in her life. It was the complexity of these issues, and the interaction between them, that had such a detrimental impact on her on-going mental health and wellbeing.

Bereavement, and subsequent feelings of loss, was a factor emerging in many accounts, including those participants from the least deprived areas. Participants had at times been subject to some incredibly difficult life experiences, and these challenges interweaved with other difficulties in people's lives to impact on their mental health. Despite this, participants nevertheless talked about surviving and strategies they used to cope. Lily spoke about how she had managed to flee an abusive relationship after being given some support from a police officer:

The last incident with him was when the police came and took him away, and

they came back to see if I was ok. He was only a young lad, and he said to me,

'I'm going to say something now. I never thought I would say it this early in my

career, but please don't let me be the policeman that comes to get you in the

body bag'. Cause he was very violent. And I left the week later. (Lily, 60)

All of the participants presented as people who were trying to cope with the things that had happened to them in their lives, as trying to get by. They had different ways in which they were dealing with these issues and for many this was an on-going process.

<u>Power Issues and Ways of Coping</u>

A key theme threading its way through this chapter is power; this was a key concept that bridged together many of the participants' accounts, and further examples of power are explored in this section. The concept of power is largely absent from bio-medical approaches towards mental distress, however there are strong links between experiences of oppression, injustice, abuse, and mental distress (Tew, 2005). Power and powerlessness were revealed in multiple areas of this research project, including around income, and experiences of the benefits system and with other formal agencies. Power emerged in relation to financial stability: the participants from the least deprived areas were in many respects in positions where they had greater power in their lives. Having financial stability gave participants the ability to live in places free of crime and deprivation. Not needing to worry about money was a source of freedom. Conversely, the participants in the most deprived areas and the CAB group were often in positions where they felt powerless: having a low income constrained the choices that were available to them, and involvement with the benefits system often placed participants in a situation in which they felt powerless over decisions that were being made. However it is also recognised that people are not just 'done to', and will exert autonomy with the choices that are available to them (Carter and New, 2004). Participants spoke about the different ways that they coped with these experiences of powerlessness.

Money as Power

Within the determinants of health literature, income is important in the relationship between socio-economic status and health because it enables access to goods and services, and allows people the ability to avoid exposure to physical and psychosocial risk factors (Bambra, 2011). For participants in the least deprived areas, having more money meant that they were able to access opportunities that would benefit their mental health. Conversely,

lack of financial freedom restricted opportunities. For the participants in the least deprived areas, finances were by and large not of concern. Participants used their income to pay for things that might benefit their mental wellbeing and give them a break from their day-to-day lives. Holidays were talked about by many participants as being something that was really important, providing a chance to have some time away and an opportunity to 'recharge'. James, who talked about how his mental health always became worse over the dark winter months, discussed how the wider family were considering buying property abroad:

We are chewing over getting somewhere in Spain. Just for the weather, for the sun, because that's another big thing for me. Winter time absolutely crushes me. I try not to let it affect me, but when we lose that hour and we go hurling into the winter time, I'm crushed. And then December, January, February, just trying to get through those three months. So between the three of us, if we do end up clubbing the money together, sixty grand between the family isn't that much. (James, 47)

Large luxuries like holidays were out of reach for participants from the most deprived areas and the CAB, where they would need to save for many months in some cases for small treats such as a trip to the hairdressers or birthday meal:

We didn't do a lot [for 50th birthday]*, we just went out for a meal. But I'd saved up from Christmas, put all my silver in one pot, copper in another pot... Cause I don't have it to be able to say 'Ah right we've got this amount, we'll go out'. You have to save for what you need.* (Alison, 50)

Being financially stable meant that participants from the least deprived areas generally did not need to worry about money. Jen, who was recently retired, was now in a comfortable position financially, and discussed how this was helping with her mental health:

Like we were talking today, and we're quite affluent now. Now John's retired, the house is paid for, all this is paid for, the lot. And John's always paid into pensions, and I have, and now we're very comfortably off. So we have no sort of money worries or anything now, and I think that's helping. Just being more relaxed. (Jen, 62)

Having enough money also provided the opportunity to engage more in social, cultural and leisure opportunities. Having the financial means to take part in different activities was reflected on as important to mental wellbeing. Participants in the least deprived areas more frequently discussed going on trips out for the day, being part of community groups such as the church choir, hobbies, meeting friends and family socially in bars and restaurants. James spoke about the different hobbies that were important to him:

I love getting out and about, love walking, love camping… I love motorbikes, passionate about motorbikes… love touring, Scotland, Wales, Spain, France. Me and a few of the lads go over. So I'm passionate about bikes, love cars, love engines, love speed, love going to see the motorbikes race… What else do I do? Work, gym, bike, walking, beer. (James, 47)

For James, the ability to get out into the countryside and be outdoors was really important for his mental health. He talked about how he would often take himself away on his bike for the weekend if he was having a bad time and needed some solitude. For Barry, alternatively, attending church and the choir were important activities to him:

I'm there most weeks. There's all sorts on, it's a good group of people… The church is a support." (Barry, 60)

Having enough income also, crucially, provided participants with options to find a 'way out' of situations that were detrimental to their mental health, such as taking early retirement or reducing employment to part-time working. The participants who were over the age of 50 in particular were more likely to have these options available to them. Dennis had previously been employed in a job that he became unable to manage. It was damaging his mental health and as he was in a position where he could afford to retire early, he took that option:

I mean it's very stressful in HMRC. It was very stressful. So I said 'I can do without this, I can get out. I've done 39 years.' That's what I did, took early retirement in May last year. (Dennis, 57)

Brenda had worked for the Job Centre for a long time and as a result of the impact of increasing stress at work on her mental health, had opted to move down to part-time employment. Although this would impact negatively on her final pension, she had made the decision to support her mental health:

*I'm already on early retirement because I already do three days a week now, because my work life balance had gone. I'd done nearly forty years there, and I just thought, 'That's enough'. So I went partially retired about eighteen months ago. Best thing I ever did. (*Brenda, 56)

This ability to use money to find a way out of a difficult situation was often not available to participants in the most deprived areas or those from the CAB. Debra, who was a similar age to Brenda, had moved to the borough following a relationship breakdown six years ago. She was desperately unhappy in her current home and had been the victim of several crimes, however was not financially in a position where she could afford to move back to the countryside in Yorkshire:

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I prefer to live in the country. There's too much going on here, too much crime and drugs and people just carrying on in the street… You can't leave your windows open on a night…I just like the open fields and the hedgerows…I would never have believed I would be in this position. (Debra, 55)

Debra felt trapped living somewhere she did not want to be, and without the financial means to be able to move to a place that she felt would make her happier.

Powerlessness and the Benefits System

A sense of powerlessness was particularly present for participants who were reliant on social security. Being caught up in the benefits system put many in a situation where they were to a large degree powerless about the decisions being made. With participants in receipt of ESA, there seemed to be a relentless process of decisions being made, benefits stopped and changed, and the person themselves having no real say about it. Alison spoke of this process and her sense of powerlessness in dealing with it, reflecting on the '*fear of the brown envelope*' a theme that has been highlighted in other research (Garthwaite, 2014):

Some days I just sit and I'm crying over absolutely nothing. And the postie comes and I see a brown envelope and I don't want to open it, because it's either the housing or the benefit, and it's just like, since all the changing over of the different benefits over the last couple of years, that's been the worst time for me, these last two and a half years to three years, benefit wise. Because at the drop of a hat they swap you onto something else. (Alison, 50)

There were many instances of participants feeling 'unheard' and 'unlistened' to. For many the system came across as an arbitrary process without any grounding in the reality of their lives. There was a very clear sense of being 'done to'. There was also a sense of the

unfairness of the system, for example in relation to sanctioning. Andy described a situation in which he was threatened with being sanctioned:

I've signed on today, I filled the form in as best as I can and I go on a job search on the internet. What else can I do? And she said 'It's not enough. We've got to sanction you'. And I don't know if she is or not. … I haven't even got a proper CV. This triage, where I go, they're supposed to help me get a CV, but he said they haven't got the time. So that he'll just do us a little one. That's what he said. But it's no good. The dole are telling me it's no good. (Andy, 46)

For participants who lived in social housing and were trying to move home, relying on systems of applying for homes put people in a situation where they repeatedly had to bid and wait without any idea of how long that waiting would take, until they reached a position where they were successful in one of their applications. 'Knowing the system', and knowing for instance, that their physical health problems may increase their priority for rehousing, was an important tool for participants to be aware of:

The places I've bidded on I've been outbidded… It just all depends on what your circumstances are really. So obviously you get rated higher if you have like kids and things and whatever, but we don't, so we're sort of like the lower priority. But with my diabetes and my mental health and my eyesight getting worse, I think they're going to move us up to a higher group. (Paul, 27)

Responding to Powerlessness

Narratives of powerlessness were present in discussions around a host of other agencies, such as social services, GPs and the police. These experiences, of negative encounters with formal agencies, were repeated often in participants' accounts. Paul, whose daughter

had been placed in foster care, spoke of his feelings of powerlessness in the process, and his anger:

> *I didn't really get a choice. It was like 'Basically we are doing it this way*, [Paul's daughter's] *mum's agreed that she should go into foster care, so we're doing in on regard of both parents'.   I didn't agree with that, I got put out of the meeting, cause I was too aggressive, shouting, arguing… We got asked to leave. I just thought 'well fuck it, you're not even attempting to help us'.* (Paul, 27)

There was at times a real sense of helplessness in participants' narratives, of not feeling in control. Participants nevertheless responded to this lack of power with the resources that were available to them. As in Paul's account above, anger was a common response. Some participants reported anger at the government and the benefits system and the impact that this had on their daily lives.   Several participants were also angry at the labelling and stigmatization of them by the government and the media, and the impact this had on their self-esteem. Jimmy was angry about the media portrayal of people who are not in work and the rise of the so-called 'poverty porn' on television, programmes that reflect dominant narratives around 'shirkers' and 'strivers' (Garthwaite, 2011):

> *It seems that now we're under attack from all angles. You just watch the television and see what's happening. How people on the dole are portrayed. It's entertainment to see a girl drunk and shouting and swearing at 2 in the afternoon, cause' that's what all people do on the dole. From Benefits Street to refugees with six bedrooms.* (Jimmy, 47)

Hannah, similarly, talked about the stigmatization of people who are in receipt of benefits and how she resisted those narrow and judgemental constructions of her identity:

Being on the benefits, you get all the stigma. 'Ah you're a single mum, you're on benefits'. You get tarred like everyone does right across the country. 'You're on benefits'. No I'm not, I'm actually a lot more than that. I was working. But I had to go on incapacity because of my condition. (Hannah, 38)

Andy had walked out of a mandated course, despite the negative consequences that this might then have. Disengagement was a decision he was able to take within the constraints of the options that were available to him. Andy had been taken off ESA and placed on JSA. As part of the requirements for JSA he was mandated to attend certain courses, and had really struggled with attending these as a result of his problems with his mental health. He discussed one experience on a course in which he felt the trainer was patronising the people in the group. This led to Andy walking out, despite the risk that he would then receive a benefits sanction:

It's not the first time I've failed with them courses. But the last one I went on was really bad like, really bad. There was loads of people walking out. They were all getting their money stopped. I thought 'I'm not staying here, if they stop my money they stop my money'. (Andy, 46)

Knowledge was a form of power: knowing your rights, challenging decisions, and using this knowledge to fight back. Participants who had accessed support from the CAB found it very helpful having an advocate to help them fight unfair benefit decisions and manage the appeals process. Alison described how the CAB had helped her in appealing against ESA decisions:

They put me onto ESA, then they decided they would take me off ESA and put me onto Job Seekers. And so I fought that, and I won that case. That's twice

actually I've been all the way through to tribunal. Over benefits. If it wasn't for Citizen's Advice I don't know where I'd be now. (Alison, 50)

Debra received support from a mental health advocate, who supported her in attending benefits appointments. She found it beneficial to have his support in representing her views:

He comes with me to these work focused interviews. Because when I get confused my mind goes blank. I just stop in mid-sentence and forget what I'm talking about. (Debra, 55)

Advocacy served an invaluable function for those participants who accessed that support. Advocacy services have, however, been under increased demand as a result of the welfare changes. These issues will be explored further in Chapter 6, when I draw in key stakeholder perspectives around the impact of austerity on services.

Summary

This chapter has explored differences in the lives of people who report having mental health problems in Stockton-on-Tees. The findings contribute important insight to the health inequalities literature, demonstrating how inequalities in people's lives are related to inequalities in mental health. It also provides insight into the role of agency, how people understand and react to those inequalities in their everyday lives. A central theme, running throughout this chapter, is the sheer complexity that exists in people's experiences. Participants were often faced with multiple issues in their lives; these are interwoven and demonstrate the complex nature of people's lives in a period where cuts in public spending and social security are impacting on the social landscape in the borough.

The role of material deprivation, structural inequality, and the impact on mental health was revealed. The findings indicate significant differences in participants' lives across a whole host of areas, including employment, finances, and the physical environment. One of the most important differences was in terms of income: participants in the most deprived areas (and those from the CAB) spoke of struggling financially and of finding it incredibly difficult to *make ends meet*. The stress that came about from lack of money had a detrimental impact on mental health. The findings support the consistent evidence base showing the link between factors relating to material deprivation and their impact on mental health, including: low income (Melzer et al, 2004); unemployment and underemployment (Rogers and Pilgrim, 2003); and living in areas with high levels of deprivation (Curtis, 2010).

Participants from the least deprived areas reported being comfortable financially: although participants from all groups had experienced problems with their mental health, money (or lack of it) was not a source of stress for this group. Participants used their income to pay for things that would benefit their mental health, such as paying for holidays that gave them a break from their day to day lives. An adequate income also crucially gave some participants the opportunity to break away from situations they perceived as damaging their mental health, such as stressful work environments. Within the determinants of health literature, psychosocial factors relating to the work environment have been found to have detrimental impacts on both physical and mental health (Brunner and Marmot, 2006). In particular for participants from the least deprived areas, this revealed the role of the work environment on their mental health and wellbeing.

Participants from the most deprived areas were often strongly connected to their communities, however they also spoke about social problems in their neighbourhoods and the impact of this on their wellbeing. In contrast, participants from the least deprived areas discussed living in safe environments. Features of the environment that people live in have been explored in the geographical literature in relation to their impact on physical and mental

health (Curtis, 2010; Cairns-Nagi and Bambra, 2013). Curtis (2010) refers to the impact of deprived environments in terms of "*landscapes of risk*", places that are damaging to mental health, and where persistent exposure to poverty and harmful physical surroundings (such as poor quality housing, pollution and run-down neighbourhoods) may contribute to increased mental ill-health. In the interviews, social problems in the neighbourhood, and with housing, were discussed by participants from the most deprived areas, sometimes (although not always) in terms of having an impact on their mental health. This was a theme in which participants from the CAB did not appear to have the same level of problems within their communities, and is perhaps reflective of them coming from *relatively* deprived parts of the local authority, but not the *most* deprived areas. Despite the social problems that were highlighted, however, many participants nevertheless had very strong ties to their communities and had often lived in the same wards over their whole lives. People were intimately connected to the places they lived. In the context/composition debate, this supports Warren and Garthwaite's (2014) argument that the places people live in cannot be separated out from the people living there, as they are so closely embedded with each other.

The benefits system has been shown to aggravate the problems people had with their mental health, with the relentlessness and rigidity of the process creating uncertainty and chronic stress. The results feed into the body of literature demonstrating an adverse impact of the welfare cuts, in particular on people's emotional health (Pemberton et al, 2014; Garthwaite 2014; Patrick, 2015). However, alongside this, my findings add an important contribution to the particular challenges faced by people with mental health problems who are in receipt of these benefits. This includes processes which effectively keep people in distress: revolving door assessments, uncertainty, increasing conditionality, and worsening financial situations all undermined well-being, preventing people from being able to move forward with their mental health. Although participants from all groups described retreating into the home and avoiding the outside world as a means to see through a period of crisis,

for participants in receipt of ESA or JSA, the benefits system permeated into their homes, breaking this concept of the home as a safe space.

This *disproportionate* impact of austerity meant that people from more deprived areas were faced with relentless pressures in their daily lives. Although participants from the least deprived areas were also dealing with mental health problems, they did not have these additional strains. It was these strains which had a chronic impact, and is a means through which austerity is aggravating pre-existing structural inequalities in the local authority. Whilst deprivation (and related psychosocial stress) was an issue before the onset of austerity, the cuts that have been implemented since are having a significant additional toll on the financial and emotional lives of the people that it is targeting. These findings will be developed further in the next chapter, when I consider stakeholder perspectives around how austerity is impacting on spatial inequalities in Stockton-on-Tees, showing how cuts are having a significant impact on more deprived communities.

Power is a theme that draws together a lot of these experiences, and has been discussed in the context of income, the power that financial stability gave to people, and the lack of power faced by participants who were involved with the benefits system and other statutory agencies. Power can be seen as a social relation, in which certain groups in society have privileged access to resources and opportunities (Masterson and Owen, 2006). The participants in the least deprived areas had more power because of the financial, social and cultural opportunities that were available to them. It was of note, however, that participants recruited from the least deprived areas did not generally come from privileged upbringings but had been brought up in working class backgrounds. They were financially stable but did not see themselves as being affluent. Therefore although they had *relative* power compared to participants in the most deprived areas, they would not be considered as being in the highest income group of the population living in Stockton-on-Tees.

Power operates through various scales, from social structures through to interpersonal relationships and the organisation of people's personal identities (Tew, 2006). The findings demonstrate these different scales at which power operates. Inequalities in power were reflected in the wider structural inequalities facing participants in the different groups, including those relating to income, employment, and the environment. However power (and a lack of it) was also demonstrated in participants' experiences with formal structures such as the benefits system, and their relationship with agencies such as housing and social services. Participants often reported feelings of powerlessness, of not being listened to and not having their voices heard. Participants did, however, try to deal with this lack of power with the resources that were available to them, including sharing resources as a means of managing on a very low income. People exert agency with the choices that are available to them (Carter and New, 2004), and this was also a clear finding from the research. Participants did not present themselves as passive victims, but instead as people who were trying to survive. Responses to feeling powerless included anger, accessing advocacy support, and strategies such as disengagement.

In the next chapter I move on to present the findings from the stakeholder interviews. This extends the case further, building a picture of how austerity is impacting on services, and evidencing further how the people who use those services are affected. I reveal how spending cuts are impacting on service provision in Stockton-on-Tees, how services are being affected, and how practitioners are responding to these challenges. The findings will reveal in more detail how austerity is shaping the social landscape in the local authority, impacting on spatial socio-economic inequalities, and on the mental health of people in the most deprived communities.

Chapter 6 A Case of Diminishing Resources and Increasing Demand: Services in Austerity

Introduction

I'd love to be able to give a positive take on things. There's lots of good work going on out there, but because of the structural inequality, because of the things that are happening to people, it's so hard to get a positive. (Jill, Community Organisation)

In this second qualitative chapter I present the findings relating to services in Stockton-on-Tees in a period of austerity, in which I will discuss the accounts of 11 key stakeholders. The chapter begins by providing an overview of the support services available in Stockton-on-Tees, giving a flavour of the services and community organisations available to residents in the local authority. I then move on to consider the key themes emerging from the stakeholder interviews. This includes a central finding that the twin problems of increasing demand, and fewer resources to meet that demand, are having a significant impact across the spectrum of services in the local authority. Stakeholders spoke of working in challenging times trying to respond to an increase in people's need; this was in the context of significant funding pressures, and increased insecurity. I discuss spatial inequalities and practitioner views around how the effects of austerity have not been evenly distributed across the local authority. In the second section of this chapter I then move on to explore practitioner perspectives around the impact of the welfare cuts on the people who used their services. These build on the findings from the previous chapter: key emerging themes were around the financial and emotional cost of the cuts.

Working Hard in Challenging Times: Support Services in Stockton-on-Tees

There are a diverse range of services providing support and advice to people who may be experiencing mental health problems in Stockton-on-Tees. This includes voluntary sector organisations, private sector providers, and more specialist mental health services provided by the local NHS Trust, Tees Esk and Wear Valley (TEWV). Within the third sector, the diverse range of available support to people includes: mental health charities; mental health drop-in centre; support services for people who have drug and alcohol problems; food banks; supported living for people who are homeless; domestic violence organisations and support for people at risk of sexual exploitation; support for people from black and minority ethnic communities; welfare advice agencies; housing support to help people maintain their tenancies; advocacy; men's projects; support for refugees; and community projects working to support deprived communities. The specialist services provided by the NHS Mental Health Trust, TEWV, include a range of community based mental health assessment and treatment services, including primary care, crisis intervention, and support for people labelled with psychosis or affective disorders, alongside inpatient assessment and treatment services. These services link in with those provided by the local authority, under a combined Adult Services and NHS Trust approach.

I interviewed 11 key stakeholders from a range of different agencies, in order to explore the types of support available to people experiencing mental distress in Stockton-on-Tees, how austerity has impacted on services, and practitioner perspectives on how their clients have been affected by the austerity programme. I interviewed practitioners from a variety of backgrounds, to look at the issues from different angles, and to explore commonalities and differences across services. Those key stakeholders included: welfare rights adviser; project manager and project worker within supported accommodation; GP; clinical psychologist; advocacy manager; mental health drop in centre worker; Director of Public Health; manager in a mental health charity; manager and trustee from a community organisation supporting

people experiencing poverty. Aside from the clinical psychologist, who gave a broader North East perspective on issues relating to psychological services and austerity, all of the other stakeholders were working directly in Stockton-on-Tees and able to give a local perspective on issues relating to the impact of austerity on services in Stockton-on-Tees.

A significant finding from the stakeholder interviews was that agencies were working incredibly hard, during challenging times, to support people who were often facing very difficult circumstances in their lives.   Peter, a GP working in the town centre, spoke about the network of services available in the local authority:

> *Within Stockton we're really fortunate that we have an amazing voluntary and community sector, we've got great food banks, we've got projects that really pick people up and support them when they are at their lowest ebb.* (Peter, GP)

Stakeholders spoke about working hard to try to provide the best service they could to clients. Good interagency relationships, including the ability to signpost people to other agencies who could offer more specialist support, were highlighted as an important strategy in pooling resources. Mark, a manager in a mental health organisation, reflected on the importance of this:

> *What sometimes happens is people go to an organisation because they want you to help them with everything. The difficult thing for organisations is 'What can I do? How can we work with other organisations to help with all of that?' I think where you get into trouble is when you start getting involved in things you're not best placed to help with, like benefits appeals. That's why we work with people like the CAB.* (Mark, Mental Health Organisation)

The Stockton Welfare Advice Network is an organisation which aims to improve access to advice for residents of the local authority, and create opportunities for agencies to work together to monitor the needs of residents. This network draws together many of the agencies that are working in the local authority, and is a means by which agencies are building up good collaborative working relationships. Jill, a manager of a community action organisation working to empower disadvantaged communities, reflected on the importance of the network, speaking about how she felt that there was good interagency working in the local authority but that this was also an area that could be improved on:

> *We work hard to work more in partnerships with others. Whilst we've only got a limited amount of resource and capacity. We've got some key partners that will come together and refer on, and we'll even do some events together. And that's really good. But there's lots of pockets of things going on that we're not aware of…So for me it's about knowing all the smaller organisations.* (Jill, Community Organisation)

Although agencies appeared to have good networking and interagency working, many of the stakeholders also spoke about increasing pressures in their own roles and agencies as a result of increasing demand and fewer resources. Jenny, a manager in a mental health advocacy service, highlighted this key issue, discussing how the advocacy service was struggling to provide support above and beyond what was necessary:

> *We're always challenged to meet the necessity, the moment of need, and beyond that it kind of falls away at the minute. You're working with a limited number of staff. It's not just our service, it's across services, across the board.* (Jenny, Advocacy)

Across the range of services, this came across as a reality for many of the stakeholders interviewed. Collaborative working was essential in this context of reduced resources, where agencies faced significant challenges in responding to need; these issues will be explored in depth in the next section.

Increasing Demand and Fewer Resources: Problems across Services

> *It needs feeding back into the system, the fact that there is a lack of services. It doesn't matter whether that's adult or children, there is still a lack of it.* (Hannah, 38)

The national picture of mental health services since 2010 is one of increasing demand for support, and fewer resources to deal with that demand. This can be demonstrated in reduced funding, both in statutory mental health services (Mental Health Taskforce, 2016), local government (Lupton et al, 2015), and in a range of community and voluntary organisations that support people who are vulnerable, marginalised, or may be experiencing mental distress (O'Hara, 2013). For instance, there has been a significant reduction in funding for services for women such as domestic violence refuges, and specialist support for women from BME backgrounds. Reduced funding for services coincides with increased demand: more people are seeking support and there are fewer resources to deal with that increase in demand (O'Hara, 2013).

This was a key theme emerging in many of the stakeholder accounts. This was not just the case in accounts of mental health services, in which there were narratives around reduced resources and increased pressures and workloads, but also in the local authority and across voluntary sector organizations, such as community projects, advocacy, and welfare rights, in which funding cuts and increasing demand were having an impact. Jenny was a manager of a mental health advocacy project supporting people experiencing mental distress. She

spoke of how increasing demand for advocacy had meant the need to now implement a waiting list for the service:

> *We never used to have a waiting list, but in the past few weeks we have. Because we've got a higher demand coming through. So at the moment we've got a bit of a waiting list, maybe 7 days. Those 7 days can make a massive difference for someone.* (Jenny, Advocacy Project)

Issues around increased demand were significant issues for welfare advice services. The welfare rights stakeholder spoke of, how, since the onset of the austerity programme, particular challenges have been placed on welfare rights agencies. The raft of welfare changes instigated since 2010 has been extensive (Beatty and Fothergill, 2016), and welfare advice agencies have been at the forefront of efforts to support people to navigate their way through the changes to the benefit system. Bill, a welfare rights advisor, spoke of the increasing demand on the service, alongside funding cuts, and the impact that this had on the agency's ability to respond to requests for support:

> *The initial increase* [in demand] *was the crash, 2008, but what's happened is that blip's not gone away. At the same time, you're seeing the decrease in the level of funding… Appointments are so far ahead that we're dealing with people pretty much on a drop-in service only. Appointments three, four weeks in advance just becomes too long for it to be useful to the individual.* (Bill, Welfare Rights Adviser)

As the timescales are so tight in submitting benefit applications, this has effectively made the appointment booking system unworkable. Nationally there has been an increasing demand on advice agencies; this has been accompanied by cuts in funding that includes restrictions

to Legal Aid, and reductions in funding from local authorities (who themselves have been under greater financial constraints) (Gibbons and Foster, 2014).

Working in this climate had an impact on the human resources of practitioners, with some stakeholders reflecting on the impact on themselves and colleagues of working in this challenging context. This was also a theme that emerged in the employment narratives of some of the participants in the least deprived parts of the local authority, particularly those working in the public sector (discussed in Chapter Five). John, a Clinical Psychologist, highlighted the emotional impact of restricted funding on the working environment:

As soon as you're aware that there's going to be tightening of budgets, you start to reduce your expectations of how that service is going to change. There's talk of that general sense of hopelessness that comes out. (John, Clinical Psychologist)

For John, working in this context had an increasing psychological impact. Peter, a GP, spoke of the implications of having fewer resources on working hours, and how this had ultimately tipped the work-life balance for many GPs:

You don't notice it week to week, month to month, but if you look back, since 2010, almost all GPs would say they spend longer in work. Most GPs already worked 12 hour days, either missing the beginning or the end of the day with their children. So a lot of people used to be able to get home for tea and to read a bedtime story to their kids. Now they get home when their kids are asleep. And that for a lot of people is a tipping point. (Peter, GP)

This climate, of increasing pressures and demands at work, had an inevitable impact on practitioners.

Space Matters: The Unequal Impact of Austerity

There are 10% of people who are totally, totally left behind. And they are the ones that are having their benefits sanctioned, fighting their disability claims, that are being judged capable for work when they're not. It's having a massively disproportionate effect on the very poorest and is widening health inequalities.
(Peter, GP)

Spatial inequalities in the local authority were discussed in relation to the increased demand for support in more deprived areas. The welfare rights adviser spoke of how, whilst more affluent areas of the local authority had seen demand for advice services remain stable, this had not been the case in the more deprived areas. This may be indicative of the disproportionate impact of the welfare cuts on more deprived areas:

You can see a considerable difference. Whereas for the richer areas, it's pretty much maintained the same numbers of clients. But for the poorer areas, the numbers have shot up quite considerably. When you look at statistics as a whole, yes there's an increase, but that's considerably higher for those poorer areas. (Bill, Welfare Rights Adviser)

The concern around increasing spatial inequalities in the local authority was discussed further by Jim, the Director for Public Health in Stockton-on-Tees, who highlighted how austerity was disproportionately affecting residents from the more deprived neighbourhoods, whilst residents from more affluent areas of the local authority had been relatively unaffected. This supports findings from the previous chapter that showed how austerity was having a particularly detrimental impact on people who were experiencing mental health problems in more deprived backgrounds:

If you are the top 10% in Stockton, you've got a great quality of life. You live in lovely housing, it's very affordable. You therefore have a high disposable income. You've got best of England health. So that's accelerating quickly. And yet at the bottom end is people who are at best stagnant, and possibly going backwards. So the gap is getting bigger. (Jim, Director of Public Health)

For the Director of Public Health, austerity was impacting on structural inequalities that already existed in the local authority. Austerity measures had not created those inequalities within Stockton-on-Tees, however had served to compound pre-existing structural inequalities:

There was nearly a 15 year life expectancy gap when we had loads of funding, before austerity was ever dreamt of. Yes the gap's got bigger, but actually there was a huge gap beforehand. So there was already poverty in Stockton, and extreme poverty. It's structural long term unemployment, lack of opportunity, poor aspiration… austerity is just another layer on that. (Jim, Director of Public Health)

This disproportionate spatial impact of austerity was a theme that was discussed by several other stakeholders. Jill was a manager in a community organisation working with people in the most deprived communities of Stockton-on-Tees. She remarked on how issues relating to the welfare cuts were specifically impacting on the communities that she worked in:

Everything to do with the welfare reforms has had a massive impact on communities that were already struggling. People who aren't managing, the view is it's always drug related, lone parents… individual responsibility, again.

Nothing to do with the structural inequality out there. (Jill, Community Organisation)

Jill highlighted popular government and policy rhetoric that attribute poverty to individual failings, as opposed to wider structural inequalities such as lack of employment opportunities and low pay (Pantazis, 2016). For Jill however it was these structural problems, as opposed to any individualistic failings, that were at the root of poverty in the community. The welfare reform programme was serving to worsen structural inequalities by increasing financial hardship. This was a view that was supported by the majority of stakeholders.

Managing the Impossible? Challenges for the Local Authority

One of the main challenges for Stockon-on-Tees is that in terms of income distribution, there is a very small 'middle' in the local authority: compared to the national income distribution there are greater proportions of residents with a high income, however there is also a much greater proportion of residents with a very low income (Joint Strategic Needs Assessment, 2013). This creates particular problems for the local authority, as 33% of the population falls in the bottom fifth of the income distribution nationally (Joint Strategic Needs Assessment, 2013). This issue was highlighted by the Director of Public Health:

That's the interesting challenge for services in Stockton. Because the bulk of your social services, and actually public services in general, are funded are for the bottom bit. But instead of us being a population where roughly 20% are the poorest, we've got much more. And that's a unique problem, a big problem for us. (Director of Public Health)

Local authorities nationally have since 2010 been significantly affected by cuts in public spending, with a fall of 33% in local government spending from 2009/10 to 2014/5 (Lupton,

2015). One of the primary functions of local government (over 60%) is to provide social care to children and adults, and as such this is a key area nationally that has been targeted for funding cuts (Duffy, 2013). The funding for mental health social care has also been affected by the reduced provision of funding within local government (Fernandez et al, 2013). At the same time as resources are threatened, however, demand for social care overall is also rising. The Care Act 2014 came into effect in April 2015 and represents a significant reform to social care legislation. New requirements from the legislation include a duty on local authorities to establish information and advice services, new rights to independent advocacy and carer support, and a need for local authorities to invest in preventative services (Social Care Institute for Excellence, 2014). As a result of the implementation of the Care Act there has been an increased demand for services from the local authority. Alongside this the ageing population is a key issue. Although neither of these drivers is specifically related to the austerity programme, the continuing trend of an increasing demand has been accompanied, since 2010, by large cuts to local authority funding:

> *National government doesn't say, 'this is what you've got for social care services in Stockton', it simply says, 'this is your national yearly allocation'. The council gets its money from two big sources, one is the central grant and the other is rates. The grant bit from government has shrunk and shrunk and shrunk. It is now less than half of what it was. And at the same time, the rate bit hasn't grown as quick, because it was never going to.* (Jim, Director of Public Health)

These twin problems, of rising demand and reduced resources, have led to a very challenging environment for local authorities across the country, and for Stockton-on-Tees at the local level. Local authorities in more deprived areas have been affected more by cuts in public spending, because the local population have greater levels of need (Beatty and Fothergill, 2016). The local authority in this case has responded to these pressures by reviewing services, including an increased focus on prevention to avoid the rise in more

intensive social care costs (e.g. Adult Services and Health Select Committee, 2013). However, in reality this has led to decisions that have not always been welcomed by the people who use services. Jill, a manager of a community organisation supporting people in poverty, spoke about a woman she was helping to represent her needs and challenge the local authority. This person received a care package commissioned by the local authority, and had now been financially assessed as having to contribute towards her care. She had also seen the removal of one of her support services within this process:

> *Because her ESA had gone up, she now has to contribute to her care. They haven't changed the threshold, even though fuel costs have gone up, cost of living has gone up. At the same time as that, because of the cuts to the local authority, this lady's shopping trip is now cancelled… that person now can't go for a shopping call each week. Look at the impact to her life, the stress, the worry, the anxiety.* (Jill, Community Organisation)

For Jill, her concern was that it was the people who used services that saw the impact of reduced resources, as agencies across the board tried to recoup costs as much as possible.

'It's a constant challenge': Working with Insecurity in the Voluntary Sector

Funding pressures were a common theme in the stakeholder accounts from the voluntary sector, although there were exceptions to this. The smaller organisations were more vulnerable to funding issues; this seemed linked to those organisations having fewer support mechanisms to bid for grant applications and secure funding. A broad finding from all of the accounts was of there being an increasingly competitive climate for grant applications. Mark, a manager from a mental health organization, spoke of increasing competition and the impact of the loss of the Northern Rock Foundation on the voluntary sector:

Northern Rock Foundation was a big casualty of austerity, and the Virgin Money Foundation, which was set up in its place, is nowhere near as broad in what you can apply for, it has nowhere near the amount of money. And the Northern Rock Foundation, in the north east, was quite a big support for the voluntary sector. We'd had money out of that, as had a lot of organisations in this area. (Mark, Mental Health Organisation)

Jenny was the manager of a small advocacy project. She spoke about insecurity for her project, and the competition for grants. As the organization she worked for was small, Jenny had greater responsibility for securing funding and this formed a significant part of her role as manager:

We're always in the constant loop of securing jobs. Once we've secured a job it's only for a short space of time, and we're always looking for funding. So it's a constant challenge. The climate has changed, and the way that you're granted funding has changed. It's much more competitive, there's a lot more focus on your strategies, business plan. (Jenny, Advocacy Project)

Stakeholders therefore spoke about the increasingly competitive climate for securing grants and funding. This was an area in which austerity had exerted a significant impact on the voluntary sector. For the stakeholders, this insecurity was said to have grown in the harsher economic climate that seen following the financial crisis in 2007/08. However, there have also been some beneficiaries of the reduced availability of funding. Mark, a manager in a mental health organisation, discussed how the organisation had managed to secure a contract to deliver psychological therapy in Stockton-on-Tees, a service which had previously been run by the NHS Mental Health Trust:

> *I suppose one of the flip sides is that because there's so much pressure on local authorities and the NHS, they are contracting out more. In Stockton the local authority has been quite open to working with the voluntary sector, and the CCG have contracted stuff out to the sector...Tees Esk and Wear Valley used to deliver it but they pulled out because they couldn't make it financially viable, so that opened up an opportunity for us.* (Mark, Mental Health Organization)

Since the 1990s there has been a long term trend in mental health, following the introduction of the 1990 Community Care Act, towards moving mental health services and care away from institutions and into the community. The development of community services has led to an 'internal market' in health and social care, with an increasing marketization within mental health, and a range of different providers commissioned to deliver services (Wilson et al, 2008).   This long term trend (with principles of marketization extended even further via the 2012 NHS Health and Social Care Act) has meant that voluntary sector organisations such as Mark's are now commissioned to deliver services that would previously have been delivered by the local NHS Mental Health Trust. In a financially constrained environment, the ability of the voluntary sector to provide these services more cost effectively is likely to be a key reason behind their commissioning.

'Inundated and Overworked': Pressures within Mental Health Services

Issues relating to increased demand were common themes discussed by the stakeholders in relation to their experiences of mental health services provided by the NHS Mental Health Trust, such as crisis services. *Having to wait* was a common theme in stakeholder accounts. Pauline, a trustee in a community organisation supporting people in poverty, spoke about a meeting in which one of the attendees discussed her experiences in the community mental health team:

This girl had to go to [local community mental health team], and she used to go, and sit and wait, and no one would turn up. They would say 'they're not here, go home'. Everybody is on the sick. Or they're called away. This girl has just been left hanging... I'm not here to throw arrows at people, it's the system that's wrong. I'm sure they do try their best, but if you haven't got the hours in the day to cope with the people, you can't do it. (Pauline, Community Organisation Trustee)

Rob was a project worker in supported accommodation for people who were homeless. He spoke of the impact of reduced resources in local mental health services, and also of the pressures around having to wait for support for clients who were experiencing a crisis with their mental health:

The crisis team, obviously they're busy, we know they are, but when you've got someone in here with an [attempted] *hanging, no one comes out, I have to ring for an ambulance. I've got someone saying 'I want to kill myself', it takes five hours for an assessment team to come out and assess… Before it used to be good. Now, phone an ambulance and it comes from Durham. Even though we have an ambulance station around the corner. If they're on call, the nearest one could be Durham. So it's a long wait.* (Rob, Project Worker)

For Rob these difficulties were a result of mental health services being so under-resourced, and problems that came about following the mergers of different trusts. For mental health services, the implications around increasing demand and fewer resources revealed a general picture, from key stakeholders, of services being under significant pressure. This reflects national level concerns around mental health services being under considerable strain (McNicoll, 2015). Jenny, a manager of a mental health advocacy project that worked

with people both in psychiatric hospital and in the community, spoke of some of the tensions within mental health services:

I think what the hospital can offer has been affected, in terms of treatments… People very rarely get access to see a psychiatrist. Services are restricted in what they can offer you, because of funding cuts. Without the voluntary sector having things available, secondary services are more restricted in what they can do, without having things to signpost people on to. (Jenny, Advocacy)

Jenny went on to discuss some of her concerns about the impact of high levels of demand:

Because of the high level of demand, how does the NHS maintain that? Some would argue that patients are being discharged really before they're ready to leave hospital, and that creates a cycle. People getting discharged early, they fall into crisis, and then they're back. (Jenny, Advocacy)

Although hospital was described as being chaotic, and not a therapeutic environment for people who were in crisis, Jenny was highlighting concerns that the pressure on hospital beds meant that people were being discharged too early, leading to unsafe discharges that meant that people were unable to cope and then ended up being readmitted to hospital. John, a Clinical Psychologist, discussed the impact of increased pressure on mental health services, and the challenges this created:

What seems to happen is all the services have pulled up their drawbridge a little bit. And it becomes a bit harder to refer people to different services… It feels like you're fire fighting, it feels like there's no space to think about actually why have

we got to this state, why are these problems growing like this. (John, Clinical
Psychologist)

Stakeholders had different ideas of how to resolve these issues within mental health
services. For some, it was purely a matter of resourcing the system better. Rob, the project
worker in supported accommodation, discussed the need for better staffing levels:

It's always going to come down to staffing. It's the workload, they might have 20
clients that they've got to see in a night. And they're literally going from one to
the next, one to the next, and if they meet someone who requires attention, the
ones that are behind are going to fall more and more behind. Because their
priority is going to be to look after the worst one, until they get them assessed.
It's all down to staffing, cost cuts, funding. (Rob, Supported Accommodation)

John spoke instead about how he felt that it was not just about funding services better, but
on a more complex level at the need to look at how the whole mental health system is set up
and operates. This echoes longstanding criticisms from the survivor movement about
mental health services and people's experiences of them as pathologising and oppressive
(e.g. Lee, 2013):

One of the arguments that happens when you talk about cuts to mental health
services is it's just asking for bigger, better services, and I don't think that's the
answer. Because what you end up doing there is you pathologize more and
more, you say the problem's located within the individual. (John, Clinical
Psychologist)

The Rise and Rise of Talking Therapies

There's been a huge demand for psychological therapies. You could argue that people are just more aware of what's there, rather than responding to need, but my instinct tells me that people are under increased pressure in their everyday lives. (Mark, Mental Health Organisation)

In addition to significant demand and resource issues in mental health services, stakeholders also discussed an increasing demand for 'talking therapies' in the local authority. Mark, above, relates this rise in demand to the increasing difficulties people are facing in their everyday lives. However, in contrast to the resource issues outlined in secondary care mental health services (such as crisis services provided by the NHS Mental Health Trust), there appeared to be relatively good provision of these types of services in Stockton-on-Tees. The Improving Access to Psychological Treatments (IAPT) programme began in 2008 and aimed to increase access to talking therapies across England, in particularly for people labelled with anxiety or depression. Peter, a GP working in one of the most deprived communities in the local authority, spoke of how whilst he rarely involved secondary care mental health services for his clients, he regularly recommended talking therapy services. He discussed how he felt there was good provision of these services in the local authority:

Access to those services in Stockton is superb. There are currently five different organisations that provide the services, they're free, they're accessible, people don't need a referral from the GP to access them. The system isn't perfect, but waiting times aren't too long, and compared to most parts of the country, we've got really good services. (Peter, GP)

Although making psychological therapies more widely available there have been numerous criticisms of the IAPT programme, including that it focuses solely on cognitive behavioural treatments, and ignores the evidence of contributory social and economic factors (Marzillier and Hall, 2009). It was also introduced with the explicit underlying economic aim of '*helping people come off sick pay and benefits*' (Department of Health, 2011: 5). John, a Clinical Psychologist, echoed his particular concerns around the wider IAPT programmes, in particular in relation to the linking of psychological therapies with employment goals:

> *In mental health there seems to be an unquestionable goal of getting people back into employment. There's no real questioning of this… What I worry about is that it's encouraging someone to stay well in an unwell system. In the same way that if someone came in who was in a violent relationship, you wouldn't be encouraging someone to cope with that. And I think that is now going on in mental health services, around coping being in this mad world without finding a way of working out what you actually think about it.* (John, Clinical Psychologist)

John's concerns relate to a drive in mental health policy to equate good mental health with employment, and an increasing use of psychology in government workfare programmes (Friedli and Steam, 2015). This has included controversial plans to co-locate IAPT therapists in Job Centres (HM Treasury, 2015), and the use of work as a 'treatment' for mental health (van Stolk et al, 2014). Employment, rather than concepts such as a meaningful life, is positioned as the prime objective in therapy. Although being unemployed can have a really detrimental impact on people's mental health, insecure, poor quality employment can also have an equally adverse effect (Bambra, 2011; Kim and Knesebeck, 2015). As John highlighted above, there are genuine concerns around this co-option of psychology, with this agenda being heavily criticised by a broad coalition of professional, grassroots, academic and survivor movements (Mental Wealth Foundation, 2016).

The stakeholders with specific knowledge of talking therapies expressed mixed views about them. The *potential* benefits of talking therapies lay in their ability to support people to feel heard and listened to, although they did not feel that it necessarily needed to be a therapeutic arena that provided this. Making human connections, including a sense of connectedness and of belonging, were reflected on as important for well-being. It did not need to be a therapist to facilitate this. Peter, the GP, felt that sometimes more social solutions were required to the problems in people's lives:

> *They often don't solve the underlying problem, the underlying stress. They don't help everyone, but for the majority of people psychological therapies are very helpful. But then there are other things that could make a big difference as well. Sometimes loneliness is a big factor, and so you don't need psychological therapy for loneliness, you need mates, meaningful activities.* (Peter, GP)

Since the onset of austerity measures Stockton-on-Tees has seen an increase in the numbers of people reporting mental health problems (Joint Strategic Needs Assessment, 2013). Whilst increases in self-reported mental health problems have accelerated since 2009, they also follow a long term national trend of people increasingly reporting experiences of mental health problems (Barr et al, 2015a). Whilst these long term increases link into debates around the increasing *medicalization of everyday life* (i.e. more people are recognising their experiences as mental distress and seeking support for them) (Illich, 1976; Lane, 2007), stakeholders also spoke of how increasing uncertainty and insecurity were impacting on people's mental health and subsequently on the increased demand for services such as talking therapies. These pressures were viewed as particularly impacting on people from more deprived backgrounds. This was a theme that was picked up by John, the Clinical Psychologist:

Is the pressure to do with people living in more insecure times? Insecure in terms of access to employment but also welfare, being unsure about what their future will be like. But there's also the stirring up of humiliation, politicians pitching strivers against shirkers. That clearly leads people to feel, and I hear this in sessions, people talking about feeling unworthy for not being able to work. (John, Clinical Psychologist)

Peter, the GP, also felt that there were increasing numbers of people, in particular those from the most deprived parts of the local authority, who were experiencing problems with their mental health. He spoke about how much of his working day was taken up with dealing with problems relating to mental distress:

My feeling is there are huge numbers of people in the poorer parts of town that are struggling with mental health problems. In a typical day, where I see 30 or 40 patients, at least a third of my time is spent managing people with stress, anxiety, depression. It's probably the most common condition that I manage. It isn't just about the poverty that people live in. I have a strong feeling that the system that they're operating within is making them ill. (Peter, GP)

For Peter the benefits system was serving to create increased levels of stress for people, contributing towards greater numbers of people in deprived areas experiencing mental health problems. These impacts of the benefits system are discussed further in the next section on practitioner views around the impact of the welfare cuts on mental health. Together the findings highlight that greater numbers of people are seeking support for their mental health, and that this is taking place in a context in which life for some has become increasingly challenging in the period since 2010.

Practitioner Perspectives on the Welfare Cuts

It's just awful out there. (Jill, Community Organisation)

Many of the stakeholders discussed the impact of the welfare cuts on the people who used their services. These were discussed negatively, as having a detrimental impact. As with the findings from participants outlined in Chapter 5, the emerging themes related to both the financial and emotional toll of the cuts.   The stakeholder narratives echoed, and complemented, the narratives of the participants, with accounts of financial hardship, of daily struggles, and of an increasing level of anxiety and stress for people. Practitioners also spoke about how the benefits system interfered in services, disrupting their ability as practitioners to carry out their work and to support the people they worked with. They also emphasized some of the specific challenges and difficulties faced by people experiencing mental health problems in regards to navigating the benefits system.

No More Good Weeks and Bad Weeks: The Financial Impact of the Welfare Cuts

Previous research has shown that the welfare cuts have been targeted at those who were already on the lowest incomes, and have had a regressive impact (Duffy, 2013; Hills, 2014). Practitioners spoke about the financial implications of the changes on people who were already managing on very low income, and how the welfare cuts had exacerbated structural inequalities, making managing day-to-day incredibly challenging. Jill was the manager of a community organisation working with people in one of the most deprived areas of Stockton-on-Tees. Trying to help people to find a way out of financial hardship was one of the key roles for her organisation, however Jill spoke of how this had become increasingly difficult:

People talk about building financial resilience. You can't build financial resilience, because people can't even get through one week. We used to deliver a money mentor programme, you'd increase income coming into the house, decrease expenditure, do a savings diary, look around for cheaper fuel. We can't do that now. Money mentoring has gone out of the window, we're dealing with crisis day in day out. (Jill, Community Organisation)

As a result of the benefit changes, the people that Jill worked with were under such financial hardship that it was often not possible to help them find a way of managing their finances on a weekly basis: clients were in a virtually constant state of crisis. Jill spoke further of how the cuts were impacting adversely on the local community, and on her day to day role at work:

Generally I get people knocking on the door for a food bank referral every day, we can only give 3 of them out to every household. I've been to PIP appeals, DLA tribunals, I'm on the phone to the DWP and you're on the phone for 40 minutes plus each time. There's a whole host of delays in benefits. Bedroom tax has crippled lots of households. (Jill, Community Organisation)

For Jill, the community had been massively affected by the welfare "reform" programme. It also permeated into her everyday work, in which supporting people with benefits issues took up an ever increasing portion of her day. One of the financial consequences of having less money, as a result of the benefit cuts, was that stakeholders spoke of people not being able to afford to participate in activities, and the impact that this had on levels of isolation. Dan worked at a mental health drop-in centre. He spoke of the impact of sanctioning on clients and their ability to attend the centre:

They get sanctioned and then can't afford the bus fare to come in. For some people it's just too far to walk, so they stop coming. We don't see them for weeks on end. We haven't seen [client] in a long time. He was having problems with his benefits, was sanctioned, and was left relying on church handouts for food. We haven't seen him in weeks. (Dan, Drop in Centre)

In this sense, the welfare cuts had served to increase social isolation. Poverty is about more than income alone: it is also about the ability to participate in activities that are considered customary in the societies that people live in (Townsend, 1979). Jill, from the community organisation, discussed the struggles that people had in participating in daily life:

You've got normal everyday life, birthdays come up, kids want to go to the pictures, go swimming. People are living day to day again, and that's the sad fact. People always want a better life for themselves, a better life for their kids, an ability to do things that would be accepted as normal. And they can't. They live day to day. (Jill, Community Organisation)

'Low aspiration' is often given as a reason for people not being able to move out of poverty (Pantazis, 2006). However for Jill, the people she worked with did not have low aspirations; they wanted a better life for themselves and their children but did not see a way out, or a way in which they could achieve this. Pauline, a trustee in the same organisation, spoke about the lack of choice for people in poverty who have mental health problems, and the contrast between the experiences of people from deprived and affluent backgrounds:

If somebody who has money has mental health problems, they can go to these spas, which helps their wellbeing; if they've got drug problems they can go into detox centres. This end of the population, they can't. When my husband was ill, we had to move, because I went bankrupt. We moved onto the council estate. I

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got the doctor in, and the doctor said 'he doesn't like living here'. I said 'I know, I don't like living here either, but there's nothing I can do about it'. People just say that poverty is a thing because you have no money. But it isn't. Poverty is a lack of choice. (Pauline, Community Organisation)

These views around lack of choice support the findings previously outlined around the power that financial stability gave participants, and the powerlessness that was often experienced when people lacked the financial means to be able to make choices or find a way out of situations that were detrimental to their mental health.

Keeping People in Distress: The Role of Welfare Induced Stress

Practitioners spoke of how the benefit changes had impacted on people's mental health and well-being, in particular in terms of increasing anxiety. For the stakeholders working directly in mental health, the welfare cuts were discussed as having a direct impact on people experiencing mental distress. John, a Clinical Psychologist, spoke of how they had affected some of the people he worked with, effectively acting as a barrier to therapy:

It becomes this big interruption. They'll get this brown letter and then suddenly it becomes very hard to focus on what we were thinking about before. And the anxiety starts to go up, they start to become more withdrawn, and also, understandably, they have that fear that if they're starting to make a change in therapy, if they show that to the assessor, then they're going to say 'Right you're now back into a place where you can get back into work, applying for 5 jobs a day'. And it's a big fear for people. (John, Clinical Psychologist)

The pressure and stress that came about from the on-going reassessments for benefits stopped people from being able to move forward with their mental health. It also effectively

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meant that the system *kept people in distress*, as the stress about assessments, and the worry about being mandated back into job-seeking, meant that people were unable to move forward in therapy. Peter, a GP, also reiterated these views around how the benefits system served to create additional levels of stress for people:

There is a lot of stress associated with Work Capability Assessments, with Personal Independence Payment claims, with having to travel to Middlesbrough to attend a course because the job centre wants someone to attend a course, having to find extra money in order to pay the so called spare room subsidy. When people are talking about what is making them feel bad, those kinds of things are a common theme. They're not the only things, but the most common external factor that people talk about is the welfare system.   Welfare system induced stress is common. (Peter, GP)

The uncertainty and stress from the reassessment process (in particular for ESA) was highlighted as being of particular detriment to people's mental health. This supports the findings from the interviews from Chapter 5, with participants who were going through this process.

The Continual Assessment Loop: Personal Independence Payments

Alongside problems with the assessment process for ESA, stakeholders also identified concerns with the transfer over to PIP (from DLA). This changeover has led to more stringent and frequent medical tests (Beatty and Fothergill, 2016). The interviews with participants experiencing mental health problems were conducted in the period from March to September 2015. At that point DLA was not yet being transferred to PIP in the local authority, and was not therefore raised as an issue by participants. However the interviews with stakeholders took place a year later, between May and July 2016. Concerns relating to

assessments for PIP were highlighted. Bill, the welfare rights stakeholder, spoke of how whilst most awards for DLA were indefinite, PIP awards are generally time limited. This means that people are facing increased reassessments:

> *The biggest problem is renewals. Being renewed early, being refused, and having to go back through the system again. We were talking about how many cases we've got where we've gone to tribunal with somebody and they've got their renewal form a few weeks later, to start the whole process all over again. We're talking about people who are on the borderline, or who have difficulties expressing themselves in medicals, so they're more likely to be refused.* (Bill, Welfare Rights)

Stakeholders spoke about people finding the medical assessments traumatising. Jenny, the advocacy manager, discussed a client who had negative experiences with the assessment process, and how being called for reassessment then had a really negative impact:

> *She was so stressed with it. Her mobility had deteriorated, and she had fear that she was going to lose something she was entitled to. If someone's had a bad experience with an assessment, it can have a really bad impact. Really bad. There's a lot of going through the welfare system that manifests itself in people's mental health.* (Jenny, Advocacy)

Chapter 5 found that some of the greatest mental health impacts of the welfare reforms involve the stress and uncertainty related to the constant, *revolving door* process of reassessments. As such, this changeover from DLA to PIP may therefore add additional levels of stress in people's lives.

'Being punished for chaotic lives': Unfair Experiences of the Benefits System

Stakeholders spoke about how the assessment process could be particularly challenging for people who were experiencing mental health problems. Jenny, who worked in mental health advocacy, spoke about how the assessment process was rigid and unable to respond to individual circumstances. This supports other research that has found that the benefits system can be discriminatory towards people with mental health problems (Hamilton et al, 2016). As an advocate Jenny faced barriers, imposed within the assessment process, in being able to support clients to represent their views:

Sometimes with people who have mental health issues, they find it very difficult to open up to a stranger. We know their needs and try and help them expand on what's going on. The assessor will refuse to acknowledge you, even though you know their difficulties with communication. They accuse you of prompting. (Jenny, Advocacy Manager)

These barriers, imposed by assessors in the medical assessments, meant that advocates found it very difficult to provide the specific support that people needed in being able to communicate their needs. Bill, the welfare rights adviser, discussed how it is clients with mental health problems who face some of the most significant barriers in accessing PIP. This, he identified, was as a result of people's needs not being understood in the assessment process, and of communication difficulties that people had in expressing their needs. Bill outlined his fears about this drive towards reassessments for both PIP and ESA:

For people who have long term needs, I have real concerns that if they're being asked to have their benefit reconsidered on such a frequent basis, what likelihood is that person going to have the wherewithal the next time around, or the support mechanisms around them, to try and seek advice? You just need

one time for that to fall apart, or you can't attend the medical, to lose your

benefit. (Bill, Welfare Rights)

Bill highlighted concerns that, particularly for people experiencing mental health problems, there may be points at which people are in crisis and unable to cope with the on-going demands of the benefit system. Because of the changes made to the benefits system in recent years, people are also now unable to reclaim the benefit if they've failed it once, unless they are able to show that their condition has significantly deteriorated. This places people in a risky situation, as not coping at one point can then jeopardize being able to receive a benefit that the person is entitled to. For people experiencing mental health problem, this could be really problematic, as when they fell into crisis this impacted on their ability to manage in other areas of their lives. This also meant that the benefits system could then become punitive, as described by the GP in relation to benefit sanctions:

People that are sanctioned are almost always people with mental health

problems, and it almost always has a detrimental effect on their mental health.

They're almost being punished for their chaotic lives. It's often being late for

something, or not turning up for something [that leads to the sanction]*, but*

usually when you drill down to why somebody hasn't gone, it's this underlying

anxiety, this fear, they're not necessarily just trying to gain the system by not

going. (Peter, GP)

Summary

This section has sought to explore practitioner perspectives around services in Stockton-on-Tees in a period of austerity, and how services have been affected by the austerity programme. It has also explored practitioner viewpoints on how austerity is impacting on

residents of the local authority.   Two key areas have been highlighted: issues of demand and resource; and practitioner perspectives around the impact of welfare cuts.   One of the central findings of this chapter is that, although services have been working very hard to meet need, this has been in the context of the twin challenges of increased demand, alongside fewer resources to meet that demand.   More people are seeking support for services and this has been accompanied by fewer resources to meet that rising demand. This has made for a very challenging period across the local authority.   These issues have been identified across the whole spectrum of services, from welfare advice through to local government and mental health services.   The majority of the stakeholders interviewed spoke of a genuine struggle to respond to rising demand amidst the context of tighter resources.

The findings reflect national level evidence that suggests that since 2010, the austerity programme has led to reduced funding and increased demand across a whole host of services, such as mental health services (Mental Health Taskforce, 2016; Thornicroft and Docherty, 2014), community and voluntary organisations (O'Hara, 2013; Mind, 2011), and local government (Fernandez et al, 2013; Duffy, 2013; Lymbery, 2012).   The findings from this research project add to this evidence base, demonstrating how reduced funding in services is impacting on services and on practitioners at a local level.

Stakeholders spoke at times of how they were only able to respond to *necessity*, as they simply did not have the resources to meet need beyond the minimum.   They also spoke of how services were tightening their thresholds for support.   All of these services can be seen to work together in a system: where there is pressure, and reduced resources, in one area of the system, this will then have a knock on effect on other areas.   So for instance, less capacity in the mental health crisis team was shown to increase the pressure on other services (such as supported accommodation) to support people who were going through crisis.   Good interagency working, and the ability to signpost on to other agencies, was seen as crucial in the context of pooling scarce resources.   Inevitably these resourcing issues

have meant that the people who use, and are in need of, services, are at the sharp end of these pressures, as they struggle to access support when they need it, or see the services that they receive reduced, or are affected by increased costs associated with social care.

Demand and resource issues were discussed in relation to the impact of welfare cuts on spatial inequalities within Stockton-on-Tees, and also how austerity was disproportionately affecting residents from the more deprived areas (whilst those from the least deprived areas were seen to have been unaffected). This is of primary importance because the local authority has the highest spatial health inequalities in England, both for men (at a 17.3 year difference in life expectancy at birth) and for women (11.4 year gap in life expectancy) (Public Health England, 2015). The wider evidence base suggests that these gaps in life expectancy have worsened since 2010 (Public Health England, 2015), suggesting that health inequalities, and associated social inequalities (which are intimately linked to health) have worsened in this period. This is not to deny, however, that Stockton-on-Tees had high degrees of inequality *prior* to 2010. From the 1970s onwards, deindustrialisation, combined with recession, led to rising unemployment and a severe decline in the old industrial economy. There was a shift towards a service economy, and a significant growth in public sector employment, although these shifts were not fully successful, with levels of unemployment remaining a significant problem for some (Beynon et al, 1994). Stakeholder perspectives suggest that austerity has served to worsen these pre-existing longstanding structural problems in the local authority.

Since 2010, government driven policies have led to the NHS making real-term reductions in investment in mental health services: this has exacerbated a situation in a sector that was already subject to chronic underinvestment (Thornicroft and Docherty, 2014). Figures gathered from 43 NHS Mental Health Trusts across England show a real term cut of 8.25% funding from 2010 to 2015; over the same period, community mental health teams

experienced a 20% rise in demand for services, alongside a 5% reduction in funding (McNicoll, 2015). These demand and resource issues in mental health services were evidenced in the stakeholder interviews, with concerns raised around the provision of community support and problems in relation to early discharge from hospital. *Having to wait* was a common theme that emerged in relation to the consequences of an under-resourced system. This links very clearly to notions around powerlessness and lack of choice in relation to service users' experiences of mental health services (Campbell, 2002).

This chapter explored the provision of talking therapies in Stockton-on-Tees and how the increased recognition of experiences as mental distress also fed into the increasing demand for therapy. These themes are supported by other research identifying long term increases in people reporting experiences of mental health problems (Barr et al, 2015), and link into wider debates around the increasing medicalization of human experience (Illich, 1976; Lane, 2007). However the research findings suggest that this process (of increasing numbers of people recognising their experiences as mental distress, and seeking support for this) is taking place in a context in which some people's lives are being made increasingly difficult as a result of financial hardship, and stress associated with the welfare cuts. Whilst relatively good provision of talking therapies in the local authority was identified, this chapter also revealed concerns around resource issues in secondary care mental health services provided by the NHS. One of the underpinnings of the IAPT programmes is their remit to support people off benefits and back into employment (Marzillier and Hall, 2009), and it is perhaps this economic rationale behind these programmes that has led to good provision of funding for these services. This highlights the contrast, however, between the under-resourcing of services for people experiencing relatively severe distress, alongside a rise in talking therapies for people whose needs are perhaps not as severe.

The stakeholder perspectives support the findings that the welfare cuts were having a detrimental impact on people in the local authority, in terms both of the financial and

emotional costs of the reforms. These findings support other qualitative research identifying a similar adverse impact (Pemberton et al, 2014; Garthwaite, 2014; Patrick, 2015). Stakeholders spoke of how the welfare cuts were placing people under greater financial hardship; this was preventing people from being able to take part in day-to-day life, restricting the choices that were available to people and their ability to take part in everyday activities. It was also significantly increasing the emotional strain that people were placed under. The increased stress that people faced in the benefits system was shown to prevent people from being able to move forward with their mental health. Specific difficulties in relation to people being able to navigate the benefits system were also discussed. These included communication barriers and inflexible assessment procedures.

The transfer to PIP was found to be problematic, mainly as the time-limited nature of the awards meant that recipients were again placed under this *revolving door* process of failing assessments, appealing, and being called for reassessment within a very short period of time. This is of particular concern given that the previous chapter identified that ESA was leading to chronic stress in people as a result of the same relentless processes of assessments and appeals. For those participants eligible to receive both ESA and PIP, this may lead to additional emotional strain.

In conclusion this chapter has explored services in Stockton-on-Tees in a period of austerity, using the perspectives of key stakeholders. A key issue has been that services are working in challenging times, dealing with increased demand and reduced resources to deal with that demand. This has been witnessed across services. Stakeholders also spoke about the impact of austerity, in particular the welfare cuts, on the people they worked with, citing the adverse emotional and financial impact. In the next chapter I move on to draw together all three results chapters, triangulating the findings in the discussion of the results.

Chapter 7 Discussion and Conclusion

Introduction

The primary aim of this PhD was to add to the evidence base around what living in a period of austerity means for local inequalities in mental health. I wanted to explore the gap in mental health between people in the most and least deprived areas of Stockton-on-Tees, and what was causing that gap. I also wanted to explore how austerity was impacting both on services and on the lives of people with mental health problems in different parts of the local authority. These questions have been explored with an innovative case study design using a mixed methods approach. Whilst most health inequalities research uses either large datasets, or small qualitative approaches, in my project I have attempted to bridge the two, enabling me to benefit from the relative merits of each. It has also meant, importantly, that I have been able to consider both structure and agency, and the interaction between the two, revealing how people respond to and interpret these structural inequalities in their everyday lives.

Whilst much research in this area has focused on health inequalities at a national, population level, this thesis has attempted to explore inequalities in mental health at a local level. The case of Stockton-on-Tees is important because it has the highest health inequalities (for both men and women) in England (Public Health England, 2015). There are particularly gaps in the research base around inequalities in mental health and this project has sought to address that gap in knowledge, using both quantitative and qualitative methods and triangulating the findings to give an in-depth consideration of this issue. Further, although there is now a body of evidence exploring the impact of welfare cuts, and lived experiences of poverty and deprivation in the UK, this project has focused on the specific experiences of people who are living with mental health problems, comparing lived experiences between those living in more and less deprived neighbourhoods. Few studies have explored the

experiences of stakeholders, and this gap in the knowledge base has also been filled by exploring key practitioner and stakeholder perspectives on the impact of austerity on services.

In this discussion section I begin by highlighting the main themes arising out of the research. I then discuss how I have answered the research questions, demonstrating how my findings add to the wider research literature. Finally I move on to explore avenues for further research and recommendations arising out of the research project, before drawing this thesis to a close with some final concluding remarks.

Main Themes Emerging from the Research Project

A key finding from this project, identified from the qualitative strand of the research, is that the austerity programme, implemented since 2010 in the UK, is having an incredibly damaging impact on the social landscape in Stockton-on-Tees. It is aggravating long-standing structural inequalities and leading to significant difficulties for the individuals and communities that it has affected. Service provision within the local authority has been affected, with services challenged with an increasing demand for services, alongside fewer resources to meet that demand. Services are struggling to find the resources to provide support. Despite agencies working hard to meet the needs of residents, these pressures have had an inevitable impact. Austerity is having a disproportionate impact on the most deprived communities, whilst leaving those from the least deprived areas relatively unaffected. In the least deprived areas, austerity emerged in people's working lives, where increasing pressures were reflected on. This included working environments where there were fewer resources and subsequently more demands and pressures placed on individuals. However for those from the most deprived areas, austerity had permeated into their financial, emotional, and social lives. Welfare cuts affected people's ability to pay for

basic necessities such as heating their homes or paying for food, driving people into financial crisis. Additionally, they compromised people's ability to take part in social and cultural activities, denying them opportunities to take part in normal and everyday activities. Despite the financial strategies they used to try and cope, this was often an uphill – and relentless – battle. Austerity had a pervasive impact, including a chronic impact on people's mental health.

Where the survey findings told us that material factors are significant drivers of inequalities in mental health and wellbeing, the qualitative interviews (both with people experiencing mental health problems and key stakeholders) then revealed how those material circumstances are worsening as a direct result of welfare cuts. These effects are on a sector of the population in which people were *already* living on a low income: welfare cuts have served to exacerbate financial hardship in people who were already managing on very little. Further, they have been shown to have a *direct impact* on people's mental health, in particular in creating chronic stress, leading some into mental distress, and compounding the difficulties that others were already experiencing with their mental health. The benefits system was shown to effectively keep people in distress, having a relentless and chronic impact.

The second central finding of this project, from both the qualitative and quantitative approaches, is that social inequalities in Stockton-on-Tees are strongly associated with inequalities in mental health and well-being. Material factors are of fundamental importance: financial stability, and the opportunities this gives people, offers considerable protection to mental health. This project has found that people's lives, circumstances, and everyday experiences are often very different across the local authority. Austerity is impacting on these material inequalities by having a regressive financial impact on those on the lowest incomes. People living in the least deprived parts of the local authority have a good quality of life, adequate income, decent jobs, and live in communities that are safe and relatively protected from crime. Financial stability gives people more power: to live in environments

free from crime, to not have to worry on a daily basis about money, to be able to access opportunities and activities that benefit wellbeing. This gives people more choice in their everyday lives: the ability to both make choices that will benefit their mental health, and to break away from situations that are harming their mental health. Conversely, poverty poses significant challenges for those living in more deprived areas. This includes issues related to living on a low income, the benefits system, unemployment/insecure employment, deprived housing, and living in communities where there are social problems such as crime and problematic drug/alcohol abuse. Poverty prevents people from being able to engage in normal everyday life, and constrains the choices that people have. The project has demonstrated the different degrees of choices that are available to people depending on their material resources, and ultimately how this impacts on mental health. Whilst people from more deprived backgrounds have agency to make their own decisions, and do so, those choices become increasingly limited when people are facing material hardship. Conversely, financial stability gives people more choice, and consequently greater power.

Lives are, however, complex, and it is not just material factors that impact on mental health. Multiple factors have been shown to interact and intersect with each other, and it is the complexity of these experiences that can make life so challenging for some. These factors include life events such as grief, loss, and abuse, the impact of physical health problems, and the interaction between physical and mental health. Although experiences of mental health problems are less prevalent in the least deprived parts of the local authority, they do still exist. For people from the least deprived areas, having mental health problems could at times make life really difficult to deal with, and people spoke about the impact of significant life events on their mental health. Whilst issues relating to deprivation did not contribute to poor mental wellbeing for that group of people, for those from more deprived backgrounds, material deprivation compounds and exacerbates the difficulties they are facing with their mental health, leading to chronic emotional strain. Poverty presents significant financial and psychosocial challenges to those who are forced to deal with its damaging effects.

People's experiences of mental distress are not situated outside of everyday experiences. Rather they can be seen as responses to the events and experiences that life has thrown at them. This adds support to approaches that recognise the social conditions under which people live. Whilst participants often discussed the role of adverse life events in crises with their mental health, on-going mental health and wellbeing was determined by other factors such as material deprivation, the ability to participate in activities and opportunities, the ability to find a way out of stressful situations. Feelings of powerlessness were key themes. Participants who were in receipt of out of work or ill-health and disability related benefits often described a sense of being completely powerless about decisions being made. This created an oppressive environment in which people regularly described situations in which their voices and views were marginalised. Although they had ways of trying to cope with this lack of power, it inevitably took its toll. Stakeholder ideas around how mental health could be improved often involved very social responses, such as helping people to have their voices heard, the opportunity to connect with other people, to have a sense of belonging, to participate in community life. These everyday opportunities are being restricted by a programme of spending cuts and ideologically driven "reforms": they are infringing on people's ability to take part in activities that would help their mental health, forcing people into situations of powerlessness, and increasing levels of distress in people who were already faced with significant challenges in their lives.

Divided Lives: Exploring Inequalities in Mental Health and their Social Determinants

In this section I explore the findings relating to inequalities in mental health in Stockton-on-Tees. Specific reference is given to the wider literature around the social determinants of mental health, and what my project contributes to this evidence base. The findings address the first research question of my project:

Are there inequalities in mental health and wellbeing between people from the most and least deprived neighbourhoods of Stockton on Tees, and what factors are contributing to these inequalities?

However, I also draw in a consideration of the how austerity measures are impacting on inequalities in mental health, as I have identified that these two research questions are related: material inequalities are key factors driving inequalities in mental health, and austerity is impacting on those key determinants. Therefore within this section I also begin to tackle my second research question:

What are the differences in the lived experiences of austerity for people who have mental health problems in different areas of Stockton-on-Tees?

Chapter 4 presented the findings from the cross-sectional survey exploring the gap in general mental health and wellbeing between people from the most and least deprived neighbourhoods of Stockton-on-Tees. For both outcome measures I found a significant gap in mental health and wellbeing. The multi-level analysis explored the key factors that were impacting on this gap, incorporating a consideration of material, psychosocial and behavioural factors. The key determinants included: socioeconomic factors such as income, receipt of housing benefit, and employment; the physical environment people are living in; psychosocial factors such as feeling happy, feeling safe in the neighbourhood, and having companionship; and key behavioural factors including frequency of physical exercise and alcohol use. Whilst behavioural factors are often privileged in public health literature, this project found that, although factors such as physical exercise played a role, it is far more important, for mental health and wellbeing, to have a reasonable income, to live in neighbourhoods free from environmental problems, to feel safe and to feel connected with others. Material and psychosocial factors were revealed as the most important determinants

of the gap in mental health. These factors interweaved with each other to have an overall impact on mental health and wellbeing. There were some limitations to the statistical analysis, including the potential for confounding variables and reverse causality, some overlap between variables, and a relatively low response rate (discussed on p89-90). Respondents were generally older than the general population and the findings need to be interpreted with this in mind. Although causal inference can be problematic for cross-sectional analysis, the findings have nevertheless demonstrated the strength of the relationships between material and psychosocial variables and the mental health outcomes. This would suggest that these are particularly important contributory factors to the inequality gap in mental health and well-being.

Chapter 5 provided further insight into factors shaping the inequality gap at the local level. This moved beyond a broad snapshot of inequalities in mental health to explore the differences and commonalities in the lived experiences of people with mental health problems in different parts of the local authority. As with the survey, it was found that multiple factors interacted to impact on people; these interweaved with each other to compound the difficulties that people faced. There were key differences in people's everyday lives, including around employment, finances, and the environment. The significant spatial and social inequality in the local authority emerged clearly in the interviews. Finally, **Chapter 6** explored stakeholder perspectives, drawing in practitioner viewpoints around spatial and socio-economic inequalities in Stockton-on-Tees, and the impact of increasing hardship in the more deprived areas on inequalities in mental health.

Together, the findings lend support to the argument that health inequalities, and inequalities in mental health, are principally driven by material factors (Scrambler, 2012; Shaw et al, 2006; Whitehead, 2014). Psychosocial factors emerged as more important in one of the mental health outcomes in the survey (SF8 MCS), however material factors overwhelmingly dominated the other (WEMWBS). The qualitative strand of the project further identified the

significant material inequalities in the local authority, and the clear impact of deprivation on people's lives. Material and psychosocial factors interweaved with each other, showing how poverty can be chronically stressful for people. People talked about significant stress in managing on a low income. For those in receipt of benefits, they also spoke of on-going anxieties about losing benefits, being reassessed, and how they would cope if those benefits were withdrawn. As with the survey, a key finding from the qualitative interviews was the importance of income. Having enough income was centrally important to a decent quality of life; it also conferred power, allowing those who had enough money to participate more fully in society, and to engage in (or break away from) situations that impacted on their mental health, such as paying for holidays to take a break, or dropping down to part-time working to deal with stress from employment. These factors were incredibly important: having more choice allowed people to take steps to improve their mental health; conversely, being financially constrained meant that people were often left feeling trapped in situations that they did not feel able to find a way out of.

Employment emerged as a key factor in people's mental health and well-being. Whilst the survey identified that being in paid employment was related to positive mental health, the qualitative interviews revealed a more complex relationship between employment and how it impacted on mental health. Participants who were not in paid employment missed work and missed the benefits that work had provided. Being unable to work (as a result of physical and mental health problems) was perceived as a loss by many participants. In particular for participants from the least deprived areas, issues relating to the work environment, such as work-related stress, were spoken about as having an impact on their mental health. This supports other research suggesting that psychosocial work factors, such as a lack of control at work, may impact on mental health (Brunner and Marmot, 2006; Niedhammer et al, 2015; Finne et al, 2014). Notably, the work environment was one area in which austerity had an impact on people from the less deprived areas. They spoke in particular of how increasing stress at work, as a result of increasing demands and tighter resources, had shaped the

work environment since 2010. For some this had led them to make decisions to remove themselves from this stress, such as reducing their employment to part-time working or taking early retirement. Having greater financial stability gave people the choice to make those decisions.

Whereas work impacted on mental health in the less deprived areas, it more frequently had a physical health effect on people living in more deprived areas (**Chapter 5**, p 146). As evidenced in other studies, participants talked about their health problems as determining their relationship with the labour market (e.g. Pemberton et al, 2016). These findings show the complicated relationships people have with the labour market, and – relatedly – the complex pathways in which employment (or lack of it) impacts on mental health and wellbeing. Many of the participants wanted to work, and missed the economic and social benefits that working had given them, however sometimes paid work was not a viable option. The findings also revealed the added emotional impact of the benefits system on people who are not in work. People's lived experiences of these processes, discussed further on p 221, reveal the chronic emotional harm that they are causing. This adds a further dimension to how being out of employment impacts on mental health. There was no evidence of a *'culture of worklessness'* that has been represented in dominant narratives (Pantazis, 2016). Within this approach, the blame for being out of work is centred on 'faulty' behaviours and attitudes within individuals and communities; the benefits system is positioned as problematic by contributing towards 'welfare dependency' and a 'culture of idleness'. People out of work are seen as those who 'won't work' rather than as people who in fact face multiple barriers in accessing paid work (Bambra, 2011). Without exception, the participants in this study who were not in employment faced numerous difficulties in accessing work. This included significant barriers posed by chronic health problems and a lack of suitable jobs to apply for. Participants presented extensive employment histories and no culture of being 'workshy' or 'idle'.

Alongside factors relating to socioeconomic issues, material factors relating to the physical environment were also important to mental health. In the survey these were less important than socioeconomic factors, although still played a role. Key factors included whether there was pollution in the neighbourhood, and whether the home itself was too dark. Related (although not identical) factors were also highlighted in the qualitative interviews. Although participants did not discuss levels of light in the home, they did discuss the impact of physical conditions such as living in damp and cold homes, suggesting a general impact of the quality of housing. Participants in the qualitative interviews were also more likely to discuss the impact of noise from neighbours, crime, or drug/alcohol related social problems. The findings combined suggest that the quality of the homes that people live in, alongside features of the community, can impact on mental health. This adds to the evidence base around the places where people live that may be damaging to mental health, including living in areas with high levels of deprivation, lack of services, lack of decent jobs, problems with crime, and a lack of green spaces (Bambra, 2016; Curtis, 2010).

Psychosocial factors emerged as being of importance across all three research strategies. These relate to experiences and emotions which give rise to stress in the body, ultimately impacting on people's physical and mental health (Marmot and Wilkinson, 2006). The chronic level of stress caused by financial hardship and by the benefits system, explored in **Chapters 5** and **6**, was one key area in which "welfare reform" had impacted on mental health via psychosocial mechanisms. Stress is a key feature of psychosocial accounts of health inequalities (Bambra, 2011; Marmot and Wilkinson, 2006), with chronic low levels of stress particularly detrimental to people's mental health; people from lower socioeconomic backgrounds are increasingly likely to be exposed to these levels of stress (Thoits, 2010). The realities of the benefit cuts meant that participants in the study were faced with considerable stress in their everyday lives. This had an on-going impact on their mental health. Within the survey, additional psychosocial variables that were related to mental health included how safe people felt in their communities, perceptions of happiness, and

factors relating to connecting with other people. Although happiness as a concept is not measured in the mental health outcomes, it is acknowledged that one would expect there may be some association between the happiness scale as a predictor and mental wellbeing as an outcome: happiness is a feature of emotional wellbeing (Westerhof and Keyes 2010). The concern around safe neighbourhoods also came through in the qualitative interviews, regardless of the area the participant came from: everyone wanted to live in places that felt safe, both for themselves and their families. The findings are in keeping with other research that has identified a relationship between the extent to which people feel safe in neighbourhoods and their mental health (Booth et al, 2012).

As discussed in **Chapter 4**, behavioural factors (including physical exercise and alcohol use) were identified as the least important determinants of mental health and well-being in the survey, although they still had a role. Increasing physical exercise was associated with improved mental health, supporting evidence that exercise can have a protective impact (Marmot, 2010). However, alcohol use had a positive relationship with mental health (the drinkers actually had better mental health scores), which contradicts evidence that alcohol can be particularly detrimental to mental health (WHO and Calouste Foundation, 2014). The qualitative interviews explored this further, however, with alcohol emerging either indirectly, when participants spoke about socialising with friends or family, or as being problematic, for participants who had developed problems with alcohol use. The findings together lend support to the idea of a more nuanced relationship between alcohol use and wellbeing than the public health literature would suggest, with other research finding no relationship between drinking level/frequency and life satisfaction, yet the presence of a 'wellbeing penalty' for those with an alcohol problem (Baumberg Geiger and MacKerron, 2016). The public health focus on reducing health inequalities often leans towards behavioural interventions and individual behaviour change (e.g. NHS 2014a, NHS 2014b). My findings add an important contribution to this literature, as they suggest that initiatives with such a narrow focus will be ineffective in addressing health inequalities. Whilst behavioural

strategies such as exercise play a small role in mental health and well-being, socioeconomic and psychosocial factors are far more important.

Alongside material, psychosocial and behavioural determinants of mental health, the life course approach suggests that mental health is the outcome of numerous interactions and processes: this includes, for instance, the frequency and duration of stressful events, and the extent to which these experiences are mediated by social supports and by other individual coping strategies (WHO and Calouste Foundation, 2014). From this perspective, mental health reflects patterns of social, psychological, and biological advantages and disadvantages that people experience as they move across the life course (Bartley, 2008). Essentially this model can incorporate material, psychosocial and behavioural factors, as it is a 'catch all' approach. The survey did not (and could not) explore life course approaches as determinants of mental health: it is an approach that would be better explored through either following people over a lengthy period of time, or by looking at life histories. However many of the participants in the qualitative interviews attributed an initial crisis in mental health to significant and traumatic life events (discussed briefly in **Chapter 5**), which offers support to the notion that key events and experiences over the life-course can have a cumulative impact on mental health.

Indeed, one of the central findings of this research project has been around the need to adopt more social models in our understanding both of general mental health and wellbeing, and mental health problems. Bio-medical models of mental health problems have become dominant in conventional perspectives, with people's experiences increasingly framed as "mental illness" (Beresford et al, 2010). However, this thesis adds support to the argument that mental distress should be situated "*within a continuum of everyday lived experience"* (Tew, 2005:16). The people in the qualitative interviews narrated their on-going mental health and wellbeing as being maintained (or undermined) by experiences in their everyday lives. The survey also reinforced how general mental health and wellbeing was determined

by these everyday experiences. Mental health is affected by broader social and environmental factors (Beresford et al, 2010), regardless of whether that is general mental health and wellbeing, or experiences of mental distress: mental health exists on a continuum of experience so one cannot be separated out from the other. There are clear links between mental health and social inequality (Morrow, 2013). The consequences of living in poverty, including the impact of unemployment, insecure and low paid employment, debt, and poor living conditions, can all increase the likelihood of people experiencing problems with their mental health (Rogers and Pilgrim, 2003). This project contributes to this literature, by showing how inequalities in mental health, and in the lived experiences of people with mental health problems, are very clearly linked in to these wider structural inequalities.

The research findings lend support to the evidence base on the social determinants of mental health, showing how, at the local level, the combination of material, psychosocial and behavioural factors contribute towards the inequality gap in mental health and well-being. This is the first UK study to statistically examine the relative contribution of material, psychosocial and behavioural factors to explaining the gap in mental health, and I have shown how material and psychosocial factors are driving this gap. This is particularly important in the context of a political and ideological programme of austerity that is shaping the social landscape in Stockton-on-Tees, having a direct and pervasive impact on the material circumstances (and related psychosocial stressors) of those in the most deprived communities. As material circumstances are so important to mental health, a continued programme of cuts that is directly worsening the financial situations of people in poverty is likely to increase inequalities in mental health even further. Power is a key theme that links people's material circumstances and their mental health, and will be discussed in the following section.

Deprivation, Power, and Mental Health

As discussed above, the negative impact of material deprivation on mental health was a common theme shared across the findings chapters. This supports a body of literature showing how poverty impacts negatively on people's mental health and wellbeing (Dreger et al, 2014; Curtis, 2010; Bartley, 2008; WHO and Calouste Foundation, 2014). Once income was established as an important determinant of mental health and wellbeing, the qualitative interviews and stakeholder accounts explored *how* having enough (or not enough) income impacted on mental health, and how people experienced this inequality in their lives. Lack of income led to heightened levels of stress. It also prevented people from having the choice to participate in social and cultural life.

As outlined in **Chapter 6** (p 195), Townsend (1979) has proposed a consensual view of poverty, in which the importance of being able to participate in activities that are considered customary in society is emphasised. This type of relative poverty was revealed through the interviews, with both participants (from the most deprived areas and CAB) and stakeholders discussing the daily struggles in being able to get by. For some, meeting even basic human needs, such as getting enough to eat or heating their home in the winter, was a significant challenge. In this context the ability to participate in social activities was often beyond what people could afford, with some describing having to save for many months just to pay for small treats such as a birthday meal. These lived experiences contrasted with the narratives of those living in less deprived parts of the local authority, in which holidays and participating in regular and varied social and community activities were commonplace. Income was a source of power, enabling those who were financially comfortable to find a route out of situations that were damaging to their mental health. Whilst the survey revealed structural inequalities in socioeconomic factors such as income, the interviews revealed people's agency: what they *did* about that lack of money and what strategies they used to cope.

For those participants who were living in poverty, feelings of powerlessness were regular themes. Lack of money significantly constrained the choices that were available to people. Feelings of not being listened to and being unheard came up regularly and this was reflected in people reporting feeling powerless over decisions that were being made, such as those relating to the benefits system. Conversely, participants who were financially comfortable reported more power in being able to make decisions to do things that would improve their mental health, or to move away from situations that were damaging their mental health. However, the role of power also emerged in the discussion of life events, such as abuse, that had led to a mental health crisis, with participants often reflecting on the role of events that they felt they had no control over. Power was not just present in terms of socio-economic factors. These issues relating to power were therefore not solely confined to people who were living in poverty.

Power may be best conceptualised, as Tew (2005) argues, as a social relationship that operates at various scales, from wider structural inequalities to more interpersonal and individual levels. People may have power in some areas but not in others. Inequalities in mental health can be seen as intersectional, where multiple aspects of identity, such as gender, ethnicity and class, interact to impact on mental health (Hill, 2016). Whilst the people in this project were largely white British (because the local authority is a very white place), and the findings need to be interpreted with this in mind, socioeconomic position played a central role. Factors relating to gender were on occasion also present, in particular in the accounts of violence, with most of the participants who had experienced childhood abuse or domestic violence being female. This highlights the importance of gendered and socioeconomic-based experiences to mental health (Williams, 2002; WHO, 2016).

Whilst issues around power and powerlessness were central themes in this project, an equally important finding – revealed through the qualitative interviews - is that people exerted agency with the decisions that were available to them. This speaks to the ever

present structure-agency debate within the sociological literature. Throughout the qualitative interviews there emerged instances of people making decisions and taking actions that dispelled any possible conceptualisation of them as 'passive victims'. The strategies people used to get by were revealed in a whole host of different areas, from living mainly in one room to save on heating costs, 'going without' to protect children from the worst excesses of poverty, to responding with anger and disengagement to situations in which people felt powerless. All of these examples demonstrate how people will make decisions to try and deal with the situations that are facing them: they are not just passively 'done to'.

The Role of Austerity: Exploring Differences in Lived Experiences

The second research question of this project aimed to explore the following:

> *What are the differences in the lived experiences of austerity for people who have mental health problems in different areas of Stockton-on-Tees?*

Whilst the first research question was concerned with the inequality gap in general mental health and wellbeing, I wanted to extend this further to consider the role austerity is playing in shaping this gap. The question also moved beyond a consideration of general mental health and wellbeing to an exploration of differences in the lived experiences of people who have mental health problems. The answers to the two questions are effectively interlinked. I have demonstrated how inequalities in mental health are driven by material inequalities: by disproportionately targeting those on the lowest incomes, austerity is impacting on these material conditions and subsequently on inequalities in mental health. Whilst the survey findings were cross-sectional, and therefore unable to assess any temporal changes as a result of austerity, the qualitative interviews were able to explore the role that austerity has played in affecting outcomes amongst people who have mental health problems.

This project adds to the research base around how the global economic crisis in 2007/2008, and resulting *politics of austerity,* has impacted on local inequalities in mental health. National level research has shown growing inequalities in mental health in the UK: these increases have only partly been explained by rising unemployment (Barr et al, 2015). Widening mental health inequalities have been attributed to welfare cuts (principally as a result of reducing income amongst those on the lowest incomes), and to stress relating to the WCA: in areas where greater numbers of people are exposed to the reassessment process, greater increases in suicides, self-reported mental health problems, and anti-depressant medication have been reported (Barr et al, 2015b). My project exposes these detrimental impacts of the welfare cuts on people at the local level, giving voice to how they are experiencing these cuts in their day to day lives. The evidence base to date suggests that the welfare cuts have been particularly damaging to mental health (Patrick, 2015; Garthwaite, 2014; Warren et al, 2014), and have led to widening inequalities in mental health, because greater numbers of people from more deprived backgrounds are more exposed to them (Barr et al, 2015b). My project lends support to this. The stakeholder and qualitative interviews have shown clearly that features of the austerity programme, in particular the welfare cuts, are disproportionately affecting those on the lowest incomes. Whilst narratives around austerity were largely absent from the accounts of people living in less deprived parts of Stockton, they were pervasive in the lived experiences of those from the CAB group and most deprived areas. These were people (and communities) who had already been dealing with issues relating to poverty and deprivation in their lives. Austerity had served to exacerbate and compound those issues, creating significant difficulties that permeated into people's lives.

Chapters 5 and **6** identified two key features of the "welfare reform" programme that were having a detrimental impact on mental health. Firstly, benefit cuts had led to increasing deprivation. Evidence suggests that the welfare cuts have targeted the poorest in society

(MacInnes et al, 2015; Beatty and Fothergill, 2016; Duffy, 2013), having a regressive impact as they bear most heavily on the poor (Hills, 2014). This was very clearly the case in my research, with participants from the more deprived areas speaking of worsening finances and significant stress around managing on a reduced income. Secondly, there were direct mental health impacts of the benefits system: the impact of revolving door cycles of stressful assessments and reassessments; increasing conditionality; and oppressive processes that left people feeling in situations of powerlessness.   Although the survey identified that being in receipt of housing benefit had a negative impact on mental wellbeing, the qualitative interviews revealed the significant stress that was associated with being in receipt of ESA, JSA, and PIP.   The interviews, both with people who were experiencing mental health problems and key stakeholders, revealed the chronic *welfare system induced stress* that people who were in receipt of certain benefits faced on an on-going basis.   This chronic stress links in with how the programme of welfare cuts is exacerbating inequalities in mental health, as it is only affecting those on the lowest incomes.

Further, this project adds an important contribution to the specific challenges faced by people with mental health problems, building on the evidence base around the general mental health impact of the welfare cuts (e.g. Patrick, 2015). The findings – from both the stakeholder and participant interviews – suggest that the relentlessness of assessment processes is effectively keeping people in distress, preventing people who are experiencing mental health problems from being able to improve their mental health.   Increasing conditionality, such as being mandated to attend courses, created specific challenges for people with mental health problems, who found it very challenging to consistently meet the requirements imposed on them by the system.   Further, stakeholders discussed how the benefits system could be punitive and inherently unfair on those who are experiencing mental health problems. This builds on other research showing discriminatory experiences for people with mental health problems (Hamilton et al, 2016). Problems were highlighted around advocates being allowed to support people to represent their views in assessments,

showing unfair practices which prevented people from communicating their needs. Stakeholders raised concerns that sanctions were disproportionately affecting people with mental health problems. The benefits system was perceived as unfairly targeting people who lead chaotic lives: the relentlessness of assessment processes meant that people in crisis, who were unable to consistently cope with these demands, were placed at increased risk of sanctioning.

Other qualitative research exploring the impact of welfare cuts has identified the '*fear of the brown envelope*' (Garthwaite, 2014), a process in which people are left in an almost constant level of anxiety around letters regarding assessments, reassessments, and changes to benefits entitlement. This was also a theme that was present in my research. However in addition to this, a finding from this project was that many participants spoke about the need to retreat from social life when their mental health was particularly bad. This was regardless of whether they came from a more or less deprived neighbourhood. The theme of the *home as an asylum* emerged as an important concept. Staying at home, and avoiding the outside world, was a strategy that people employed to 'see through' a period of distress until they started to feel a bit better. For those in receipt of out of work or ill health related benefits, austerity permeated into the home, breaking that concept of the home as a safe space in which to avoid and retreat from the outside world. This again demonstrates how the benefits system was keeping people in distress. For those who did ignore this outside world, they then risked punitive responses.

Other research has identified the stigmatising experiences of living on a low income: this includes increasingly negative portrayals of people who are in receipt of out-of-work benefits (Pemberton et al, 2014; Baumberg et al, 2012) and a hardening of public perceptions towards people who are living in poverty (PSE UK, 2013). These dominant discourses around poverty have been shown to impact on people's self-esteem, having an adverse emotional impact (Garthwaite, 2014). Within this project, increasing stigmatization was

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revealed both in participants accounts of the anger they felt at the labelling of them by government and the media, and the impact that this had, and in stakeholder perspectives around service users' feelings of humiliation, and of feeling 'unworthy' about being unable to work. This hardening of attitudes towards people in poverty feeds in to the mental health impact of living under austerity, suggesting that damage to self-esteem is also being inflicted by these pervasive discourses.

The Impact of Austerity on Services

The final research question concerned the impact of austerity on service provision in the local authority:

How have mental health and public services in Stockton-on-Tees been affected
by austerity and how have they responded to these challenges?

This issue was tackled in depth in **Chapter 6**, when I presented the findings from stakeholder perspectives, and demonstrated that cuts in public spending were having a key impact on service provision. Demand and resource issues were evidenced across the spectrum of services, from local government through to secondary care mental health services and the voluntary sector. More people are seeking support, and there are fewer resources available to meet that increase in demand. The stakeholder interviews revealed that the twin challenges of reductions in funding, alongside increasing demand, were having a significant impact across a whole range of services in the local authority.

The findings add to the social policy evidence base around how funding cuts are impacting on services and on their ability to respond to need. As described in **Chapter 6** (p 176), evidence suggests that since 2010, these resource and demand issues have impacted on

the landscape of services in the UK, from the public sector through to voluntary and community organisations, and mental health services (Mental Health Taskforce, 2016; O'Hara, 2013; Fernandez et al, 2013). There is however little academic research that considers the impact of austerity on services, and my findings add support to this evidence. Stakeholders from an array of services spoke of the incredibly challenging task of meeting increased demand with fewer resources. The narratives from local government demonstrated the particular challenges of trying to respond to a significant decline in funding. Nationally, evidence suggests that the local authorities most affected by the spending cuts have been those in the most socially disadvantaged areas (Pearce, 2013), and at the local level, an almost fifty per cent cut in government grants is having a profound impact on the local authority's ability to respond to increasing demand. Whilst the local authority has responded to this challenge by making "efficiency" savings, and trialling initiatives that provide early intervention (with the aim of intervening sooner to reduce more expensive care costs later on), it faces a virtually insurmountable battle in dealing with relentless cuts in funding.

This is a picture that is reflected across the whole of the North East, with a total of £966 million lost to the wider region since 2010 (O'Donoghue, 2016). Public services have been significantly cut and 19 per cent of public sector jobs have been lost to the region; these losses have not been accompanied by a comparable growth in private sector employment (Lavery, 2015). The reality for many local authorities across the North East is that it has become necessary to radically review and reshape the provision of services. This is especially the case within adult social care, in which there have been widespread cuts in services, changing eligibility thresholds, and increased care costs (Lupton, 2015). The lack of resources inevitably feeds down to impact on the people who need support from the local authority. It is those who need support and services who bear the brunt of spending cuts, and these are often the same people who are bearing the brunt of other cuts, such as those to welfare benefits. The widespread level of cuts means that those with some of the highest

support needs in Stockton are faced not just with cuts to welfare benefits, but also with reductions in the level of support they receive.

Accounts of mental health support suggest a complex picture of the provision of services. The local authority has relatively good provision of 'talking therapies', and indeed this appears to be a growing 'industry'. The rise in talking therapies was discussed in relation to the increasing *medicalization of human experience* (Ilich, 1976; Lane, 2007). The trend towards greater numbers of people recognising their experiences as mental distress can be linked to the rise in dominance of bio-medical models and diagnostic psychiatry (Lewis 2009). However, since 2010 this trend has also taken place in a context in which, for those at the lower end of the income spectrum, their lives have become increasingly challenging as a result of austerity measures. This is contributing towards greater numbers of people facing problems with their mental health. Alongside the increased provision of talking therapies, however, there were also problematic narratives around services for people experiencing more extreme levels of distress. This supports nationwide concerns around chronic under-resourcing in mental health services (Mental Health Taskforce, 2016; Thornicroft and Docherty, 2014). In reality, as discussed in **Chapter 6** (p 185), this under-resourcing means that people in a crisis with their mental health are left in situations in which they have to wait for support, or cannot access the help that they need. This is unsafe and unacceptable; it places people at risk and means that they are left in unnecessarily high levels of distress.

Whilst my findings identified how agencies have been working incredibly hard to pool resources, share expertise, and provide the best services they can to local communities, practitioners also highlighted how they increasingly felt like they were 'fire-fighting', unable to provide support above and beyond what was necessary. This had an impact on them as practitioners but also had broader implications, with concerns that some of the more protective and supportive functions provided by key agencies were being eroded. With such

widespread cuts in funding, social safety nets are becoming increasingly vulnerable, and services across the board are struggling to meet rising demand. A continuation of spending cuts will likely lead to the further erosion of services, providing further constraints on the ability of services to provide support to communities. It is of real concern that this may lead to further fragmentations of social safety nets.

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Mental Health & Place: Spatial Inequalities in Stockton-on-Tees

In this section I consider how my findings – from both the survey and qualitative interviews – contribute to the literature on the role of place in inequalities in mental health. Stockton-on-Tees has been an important case to explore inequalities in mental health in a period of austerity, because it has such high health inequalities. As discussed in **Chapter 6** (p 181), the challenge for Stockton-on-Tees is that the local authority has a large proportion of people at either extreme (Joint Strategic Needs Assessment, 2013). The "welfare reform" programme has been targeted overwhelmingly at those who are already living in poverty (Duffy, 2013), and the local authority therefore has a high proportion of people who fall into this group. As the welfare cuts are having a regressive impact (Hills, 2014), these are impacting on spatial socioeconomic inequalities within the local authority.

Spatial inequalities have been clearly identified throughout this project, from the gap in mental health and wellbeing in the survey, through to inequalities in income, employment, place, and power in the qualitative interviews, to stakeholder perspectives on longstanding structural inequalities in the local authority. Stakeholders outlined concerns about growing inequality and the impact of welfare cuts on the lived experiences of people in the most deprived communities, demonstrating how austerity is aggravating those structural inequalities in Stockton-on-Tees. The findings built on the narratives of those who were dealing with the effects of the austerity measures. Within the geographical literature, the

context/composition debate has been proposed to explain why there are spatial inequalities in health. Whilst compositional variation results from the attributes of individuals in an area, contextual variation focuses on the importance of *place*, on the independent impact on health of the places that people live (Curtis, 2004). Studies confirm that although health inequalities are strongly related to compositional factors, that this does not account for all of the variation, confirming an important role for place in explaining spatial inequalities in mental health (Bambra, 2016; Curtis, 2004).

This project adds to the evidence base around the impact of place. Whist the survey mainly focused on the role of compositional factors, it also incorporated some consideration of the impact of the environments people were living in. A significant impact of place was identified. Although this was not a comprehensive exploration of contextual factors, it supports evidence that features of the environment can impact on general mental health and wellbeing (Curtis, 2010; Cairns-Nagi and Bambra, 2013). This impact of place was explored in more depth in the qualitative interviews; participants spoke about the places they lived and the impact of their home environments on their mental health. This was an area in which the experiences of people differed between those living in the most deprived parts of the local authority and those recruited from the CAB (who lived in deprived areas but not the most deprived LSOAs). Whilst these participants reported similar experiences in regards to issues such as income, employment, and the benefits system (in many ways meaning they could be combined into the same group), those in the most deprived areas spoke of dealing with more significant social problems in their communities, and for some (although not all) participants, these impacted on their mental health. This supports the evidence base that living in deprived places can adversely impact on mental health, that place does matter (Rogers and Pilgrim, 2003; Curtis, 2010).

For participants from the least deprived parts of the local authority, their physical environment was beneficial because it did not have those features of deprived environments

that were damaging to mental health. Whilst they did not speak of their home environments as directly impacting on their mental health, they spoke of living in neighbourhoods that were safe, that were free from crime, that were 'nice areas' to live. The 'therapeutic landscapes' literature discusses the beneficial impact of certain natural environments on mental health, such as access to woodland or the coast (Curtis, 2010; Cairns-Nagi and Bambra, 2013). Whilst living in the least deprived areas of the local authority, these participants were still living in urban areas, and for those who discussed the benefits to their mental health of features such as green spaces and woodland, they generally needed to travel to benefit from them. However these participants had the financial means to do this.

Despite some participants from the most deprived areas of Stockton-on-Tees reporting significant social problems in those areas, they also had very strong attachments to their communities, often having lived in the same wards throughout their entire lives. Some of the older participants (from all groups) could chart how their communities had changed and evolved over time, alongside their own life trajectories. This lends support to Warren and Garthwaite's (2014) argument, discussed in **Chapter 5** (p 154), that the places people live cannot really be separated out from those who are living there, as they are so closely intertwined with each other. This perspective adds to the argument that there is a false dualism between context and composition: people have relationships with the places they live and these relationships are dynamic, changing over time (Cummins et al, 2007).

As this project was a case study of Stockton-on-Tees, one area for consideration is whether the results can be generalised to other places. It was chosen as a case to explore health inequalities because it has the highest health inequalities in England (Public Health England, 2015), although social inequality within the local authority can be compared to other areas within the North East. Across the Tees Valley region as a whole (comprising Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland, and Stockton-on-Tees) there is significant inequality: 38% of the region lives in the 20% most deprived LSOAs nationally,

whilst 15% are in the least deprived 20% (Tees Valley Unlimited, 2010). There is therefore a high degree of inequality across the whole region. Stockton-on-Tees has the highest amount of social inequality because there are relatively high proportions of the population at both extremes. Whilst Middlesbrough (the adjacent local authority) is much more deprived as a whole (31% of the population live in the most deprived 5% of LSOAs nationally, compared to 11% of Stockton), it has a far smaller proportion of people living in the least deprived 20% of LSOA's nationally (6% of the population compared to 25% in Stockton-on-Tees) (Tees Valley Unlimited, 2010). Therefore whilst places such as Middlesbrough may be more deprived overall, they are less unequal. My research suggests that it is this social inequality which drives inequalities in mental health.

I would argue that the project findings around *how* inequality impacts on mental health, and the evidence around the social determinants of mental health, may be generalizable to other places. Whilst Stockton-on-Tees is particularly unequal (relative to other local authorities in the area), there remains high degrees of social inequality across the region, and across the UK as a whole (Dorling, 2015). There will be features of Stockton, and the relationships between people and where they live, that are unique to the area. However, the broad impact of social inequality on inequalities in mental health, and of issues such as increasing material deprivation and the "welfare reform" programme on mental health and wellbeing, may be generalizable to people's experiences in other areas.

As a final note on spatial inequality, Stockton-on-Tees, has, along with other local authorities in the Tees Valley Region, now agreed plans for greater devolution of powers from central government. The Tees Valley Devolution Agreement will see the creation of a Combined Authority (to be established in 2017), with an initial transfer of powers for employment and skills, transport, planning and investment (Sandford, 2016). It is currently unclear how this, (or indeed the future withdrawal of the UK from the EU) will impact on the social landscape in the local authority. Initiatives to boost economic growth in the region (via the Tees Valley

Investment Fund) have the potential to improve the availability of decent employment opportunities, and to therefore tackle some of the longstanding structural inequalities within the Tees Valley. However, it remains to be seen how these processes of devolution will play out to impact on spatial inequalities.

Areas for Further Research

There are several key areas for further research. Firstly, one of the clear findings from this research project has been the emotional harm wrought by the benefits system on people who have problems with their mental health. The programme of welfare cuts is having a regressive impact and is bearing most heavily on those on the lowest incomes. The benefits system is an ever-shifting area of social policy, and the effects of on-going changes to the social security system on people's mental health will require further analysis. Upcoming welfare changes post-2015 are numerous but include: the full transfer of all clients from DLA to PIP (this is expected to be completed by 2018); reductions in payments and thresholds for tax credits; reductions in payments for ESA; a new (lower) benefits cap; and a four year freeze in the value of most working age benefits (Beatty and Fothergill, 2016). All of these changes will likely have a further impact on the most deprived communities.

Whilst there is a body of evidence now demonstrating the emotional harm caused, in particular, by ESA and the WCA (e.g. Warren et al, 2014; Barr et al, 2015b), there is less research exploring the impact of the move to PIP. As the transfer to PIP has seen a change to time-limited awards, it is likely that similar mental health effects (associated with the relentlessness of the assessment process) will emerge. The move to PIP also involves a drive towards a deliberate reduction in the numbers of people eligible to receive the benefit (O'Hara, 2013). As such there will be significant numbers of disabled people who are no longer entitled to receive support to help them with the costs of living independently. This

requires further research. Although I was able to explore PIP in the stakeholder interviews (key practitioners indeed highlighted concerns with the assessment process), the timing of the interviews with participants experiencing mental health problems meant that they were not at that point in receipt of PIP.

Additionally, the rollout of Universal Credit, and the effects of this on people who are transferred over to it, will be a key avenue for further research. Universal Credit is a benefit that is scheduled to replace just about all means-tested working age benefits: it is best understood as a repackaging of existing benefits (Beatty and Fothergill, 2016). Its implementation has been problematic, slow, and in Stockton-on-Tees at the time of interviews with stakeholders, it was only being applied to a small number of single people. An example of one of the myriad potential issues with the transfer concerns the move of Working Tax Credits over to Universal Credit. Instead of the current system, which looks at likely earnings over a year, Universal Credit will look at earnings every month. For people where those earnings vary, there is supposed to be real time information in the system about how much people have earned. However, if there is a delay between real time information and receipt of the benefit, this leads to the possibility that people will receive under/overpayments. Also, claimants who have been used to receiving the same amount of tax credit every month, and have worked out their income and expenditure accordingly, will now see that level fluctuate with their wages. This may make budgeting increasingly complicated. Universal Credit will also move benefit payments from a fortnightly to a monthly basis. This project has shown how some people are struggling to manage even day to day as a result of financial hardship: moving payments to a monthly basis may exacerbate this situation. It will require further research to explore how these potential issues, and the impact of welfare changes post-2015, are playing out and shaping the experiences of people who need this support.

A second important area for research will be to explore any temporal changes to inequalities in mental health and wellbeing in Stockton-on-Tees. Whilst for the purposes of my research project I analysed the survey data as a cross-sectional 'snapshot' of inequalities in mental health in the local authority, the wider project this PhD forms part of has a prospective cohort study design. Therefore the same people who were interviewed at baseline (and whose findings I presented in **Chapter 4**) have been followed up over a period of time (18 months), being re-interviewed every six months to look at any changes in their health, mental health, and the determinants of health. The longitudinal analysis for the survey, in which I will be involved, will allow us to identify whether the gap in mental health has changed in that time period. The social world is a dynamic, changing entity, and longitudinal approaches have the ability to reflect this (Ruspini, 2002; De Vaus, 1991). Although the wider project commenced after the onset of the austerity programme in the UK, and as such will be unable to directly link changes at the micro level to the implementation of austerity based changes, it is able to explore those changes during the current period. As such it will allow us to reflect on what happens during a period of unprecedented cuts to the welfare system, and within an ever changing social policy landscape. This will provide further statistical evidence about whether the mental health gap in the local authority has grown worse, and what factors (if any), have contributed towards this change. It will be of particular interest to identify whether the key determinants of the gap in mental health and well-being have changed over that time frame, and whether their relative contribution to explaining the gap has also changed.

Key Messages for Policy Makers

There are several key implications arising out of the research project, and this section discusses those key messages.

Recommendation 1: Revise the assessment processes for Employment and Support Allowance and Personal Independence Payments

One of the key research findings was that the on-going, *revolving door* process of failing assessments, appealing, passing appeals, and then being reassessed within a very short space of time led to chronic stress for people. The system effectively *kept people in distress*, as the uncertainty and relentlessness of the process undermined people's mental health and wellbeing. The results feed into a body of research documenting the adverse impact of ESA and the WCA, in this project having a specific emphasis on the impact on people with mental health problems. It is of real concern that a similar process (of regular reassessments) is now in place for PIP. The medical assessments themselves created significant amounts of distress for people, and were perceived as discriminating against those with mental health problems, having a heavy reliance on physical needs and capabilities.

It is a recommendation of this thesis that policy makers revise the assessment processes for both ESA and PIP. A principal concern highlighted by participants and stakeholders was in the relentlessness of the assessment process; it is therefore a recommendation that revisions are made to prevent people from being stuck in an almost constant reassessment loop. This would reduce the levels of stress that people are placed under and would give people more space to try and move forward with their mental health, without having to continually deal with the anxiety about being reassessed and the potential loss of that benefit. For people who are experiencing mental health problems, there may be points at which they fall into crisis and are unable to cope with the repeated demands imposed by the benefits system. As such, if people fail an assessment appeal, or do not manage to attend, this means they are unable to reclaim that benefit unless they can show a significant deterioration in their condition. It is unfair that people are placed at risk of losing their benefit directly as a result of falling into crisis with their mental health. Although a compassionate

approach is at odds with the welfare system that we currently have in the UK, policy makers would be wise to introduce more understanding into the assessment process.

Further, it is recommended that the medical assessments and criteria are reviewed to ensure that they do not discriminate against mental health. This project has found that people with mental health problems experience specific difficulties in accessing ESA and PIP. These issues need to be addressed, including a review of how to ensure that mental health needs are adequately incorporated into assessment criteria and thresholds, and that the communication barriers that may be faced by people experiencing mental health problems are resolved. This may include revised guidance to assessors to allow advocates to fulfil their roles in assessments.

Recommendation 2: Address poverty and deprivation as central strategies in initiatives for improving mental health

This project has found - overwhelmingly - that issues relating to poverty and deprivation are central determinants of poor mental health: financial hardship has an incredibly damaging impact. People on the lowest incomes in Stockton-on-Tees are facing daily challenges in meeting even the most basic of needs, such as getting an adequate diet, or being able to heat their home. Further, poverty is preventing people from being able to fully take part in cultural and social life. Life on a low income creates chronic stress; this has a significant impact on people's mental health and wellbeing. Having a sufficient income is also a source of power: it allows people to take opportunities that will improve their mental health, and to move away from situations that are damaging to their mental health.

The public health literature, although accepting of the material drivers of health, continues to focus heavily on the behavioural determinants of health, and behavioural interventions to address health inequalities. It is a firm recommendation of this thesis that policy initiatives

should therefore focus on reducing issues relating to material deprivation as a fundamental concern. Raising the incomes of those who are the poorest in society would do more to improve mental health and wellbeing than initiatives such as those to reduce loneliness, or that try to engage people in sports. Whilst these play their role, this project has shown the over-riding importance of an adequate income to a good standard of life.

To achieve this, it is recommended that policy makers focus on tackling low income, both in respect of low paid and insecure employment, and in-work benefits, but also on the incomes of those who are not in work and in receipt of out of work or disability and ill-health related benefits. The financial hardship that those on the lowest incomes in society are facing is making people's mental health worse. Disabled people, including those who are unable to work as a result of mental health problems, have been particular targets for the "welfare reform" programme and this has led to worsening financial situations for this group of people (Duffy, 2013). This is serving to widen income inequality in the UK even further.   To genuinely address inequalities in mental health, these regressive policies need to be reversed, with the government focus shifting towards raising incomes so that people are supported out of poverty. There are huge amounts of wealth in the United Kingdom, yet this wealth is held by a tiny proportion of residents (Dorling, 2015). A progressive tax and benefits system, that begins to adequately tackle income and wealth inequality, would do much to impact on inequalities in mental health and wellbeing.

In an investigation into the UK welfare state, the United Nations Committee on Economic, Social and Cultural Rights (2016) condemned the damage caused by austerity measures introduced since 2010, calling for a reversal of the cuts in benefits imposed by both the Welfare Reform Act 2012, and the Welfare Reform and Work Act 2016. The United Nations report argues that social benefits must guarantee a level of income that is sufficient to ensure an adequate standard of living.   These recommendations are wholeheartedly endorsed by this thesis.   Addressing financial hardship is fundamental to supporting

improvements in mental health and wellbeing; alongside this, an adequate standard of living should be seen as a fundamental human right.

Recommendation 3: Increase the provision of, and funding for, advocacy services

An important outcome of this research project is that advocacy has a central role in enabling people who feel in positions of powerlessness to represent their views and have their voices heard. Feeling 'listened to' emerged as being centrally important in this project. People often felt powerless about the decisions that were being made, and this impacted on their wellbeing and on their ability to feel that they could challenge decisions and be heard. Under the Care Act 2014, the local authority now has a duty to ensure that people are supported to ensure their needs, views and wishes are heard, and that independent advocates are appointed if people are unable to do this themselves and do not have someone who can help them to do this. However, this duty is only in relation to certain instances, such as social care assessments and in safeguarding procedures. This project has found that advocacy was an important tool across a whole range of areas, including people's access to the benefits system, having their views heard at benefits assessments, involvement with mental health services, and the dealings that people had with other statutory agencies, including social services. Advocates served a vital function in helping people to navigate these processes and it is therefore a recommendation of this project that there is increased funding for, and provision of, advocacy across the local authority.

The advocacy provided by welfare advice agencies was crucial in helping people to deal with the benefits system. This included support with filling in assessments, alongside subsequent support to challenge and appeal unfair decisions. Funding since 2010 has been a significant issue for welfare advice agencies, and this has been accompanied by increased demand, with greater numbers of people requesting support and advice. These agencies serve a vital

role, in particular in relation to helping people to navigate a benefits system that is continually evolving. As such it is recommended that more resources are put in place to help these agencies continue in their invaluable role.

Conclusion

The austerity programme that was initiated in 2010 is serving to impact on spatial inequalities in mental health in Stockton-on-Tees. Whilst the survey identified the material drivers of inequalities in mental health and wellbeing in the local authority, the qualitative interviews then explored how austerity was impacting on services, and on the lives of people experiencing mental health problems, in different parts of the local authority. The qualitative interviews unpacked the survey findings, giving voice to people's experiences, and showing how austerity measures such as the "welfare reform" programme were impacting on the lives of those on the lowest incomes. Public spending cuts have led to a climate of significantly tighter resources: this has impacted on the ability of services to respond to increasing demand. Whilst increasing demand was not always related to austerity measures, reduced resources were a direct consequence of cuts in spending and funding. This created significant challenges for services. Ultimately, it is those who receive those services who bear the brunt of spending cuts. These are often the same people who have been affected by cuts in other areas.

This project has used a case study design to expand knowledge around the effects of austerity on local inequalities in mental health. There has been a lack of academic attention given to the effects of austerity on health inequalities at the local level. However the local context is important: where you live is important to mental health, and austerity is disproportionately impacting on some areas more than others, affecting spatial and socioeconomic inequalities. This thesis has filled that gap in knowledge, providing evidence

around structural inequalities, their relationship with inequalities in mental health, and differences in the lived experiences of austerity for people with mental health problems in this very unequal place. It is also the first UK study to assess the relative contribution of material, psychosocial and behavioural factors to explain the gap in mental health and wellbeing. The project builds on existing knowledge around the impact of austerity measures on people's lived experiences, with a specific focus on people who report having mental health problems, and an examination of inequalities in their lives. Stakeholder perspectives on how austerity measures are impacting on services have been largely unexplored, and this was addressed in the final strand of this project.

By combining robust research approaches, and extending the case, I have been able to explore not just the inequalities that exist in Stockton-on-Tees, and their relationship with inequalities in mental health, but also how people understand and react to these inequalities in their everyday lives. This is important, as it shows that people are not just passive victims of structure, but also employ agency in the social world in which they live, responding to and transforming those structures. This is the first study to employ this combination of techniques in researching this issue, and it adds a level of depth to our understanding of local inequalities in mental health. As with Jahoda et al (1972), I argue that our understanding of issues can only be achieved by looking at a case in different ways and by using different perspectives. All of the research methods have been effective at demonstrating inequalities in people's lives in Stockton-on-Tees, and the relationship of those inequalities with people's mental health. Using different methods has meant I have been able to explore this comprehensively by gathering different sources of information and triangulating those findings.

This thesis offers an insight into how the social conditions that people live in shape their mental health, and how the combination of different issues, such as income, employment, and the physical environment, combine and interact to impact on mental health. It adds to

the evidence base around the social determinants of mental health, showing how factors at the local level are interweaving to impact on inequalities in mental health and wellbeing. Further, it shows how the austerity programme has made a significant mark on the social landscape in one place, aggravating structural inequalities and having very real and damaging consequences on communities that were already struggling with issues of deprivation. It also gives a voice to the lived experiences of austerity of those who are dealing with mental health problems in different neighbourhoods, demonstrating inequalities in their lives, and the particular challenges faced in the more deprived communities. This adds important contributions to the health inequalities literature, showing how factors relating to deprivation (or lack of it) impact on people with mental health problems, alongside how the ideologically driven "welfare reform" programme is undermining mental health and wellbeing, keeping people in distress, and having a chronic impact on lives.

We know that *how* the state responds to economic crises determines its impact on health (Stuckler and Basu, 2013). In the UK, the coalition government's response to the crisis was to instigate a series of cuts in welfare and cuts in public spending. This is impacting on social inequality in the local authority, and is ultimately impacting on the mental health of the people who are bearing the brunt of those spending cuts. Whilst poverty and social inequality were problems in the local authority before the onset of this programme, these inequalities are being exacerbated in the current period. My argument is not that the austerity project has created inequalities in Stockton-on-Tees, but that for those on the lowest incomes, they have been placed under greater financial hardship, they have faced significantly more stress as a result, and this has had an inevitable impact on their mental health. Whilst those on the lowest incomes have borne the brunt of the austerity programme, residents at the other end of the income spectrum have experienced little change. It is this disproportionate impact that is aggravating inequalities in mental health.

Politically the programme of austerity measures were outlined as an economic necessity, as a need to balance the £103.9 billion budget deficit held by the United Kingdom in 2009/10 (Lupton, 2015). However, Hall et al (2013) argue that in reality austerity has been a project to justify the ideological aims of the government, to justify a further entrenchment of the neoliberal model. This has included a move towards shrinking the role of the state, and a further restructuring of the state along market lines. This thesis bears witness to how the austerity project has impacted on, and continues to impact on, the social landscape of Stockton-on-Tees. The post-war welfare state was developed with the principle of trying to ensure that people had sufficient income at times when they were unable to work (in childhood, old age, unemployment, or as a result of sickness); it is based on the idea that benefits and services should go to people according to their need (as opposed to whether they can pay for it) (Hills, 2014). These principles are being eroded, with dominant narratives increasingly attributing poverty to individual choice, and individual responsibility, removing the responsibility of the state to ensure that its citizens do not have to live in poverty. These narratives are permeating public discourses, with increasingly stigmatising rhetoric and media representations all leading to a hardening of perceptions of people who live in poverty (PSE UK, 2013). The austerity programme is, as Hall et al (2013) would argue, a deliberate attempt to further remove the responsibility of the state to look after its citizens, to make poverty, and the route out of poverty, an individual problem. Social safety nets are being removed to such an extent that people are increasingly left without enough income to be able to eat. This is not acceptable. Poverty is a social – and a political – problem.

The framing of this political project as austerity may now be drawing to a close. Following the 2016 EU referendum, and subsequent resignation of the prime minister David Cameron and his chancellor, George Osborne, the archetypes of the austerity project that, since 2010, has dominated politics and social policy, have been removed from power. Cameron's replacement by Theresa May has meant that the language of austerity, and the social

construction of this project, is now being reframed. The new prime minister argued in her first Prime Ministers Questions, on 20th July, 2016, that this was not about austerity, but rather *'living within our means'*. The government no longer needs to justify their project using the language of austerity. Effectively austerity has become the new normal, an approach in which the state no longer needs to account for widespread and damaging cuts in social security support and spending in local government.

Whilst government is being challenged by opposition parties, with some successes, there are few signs of those regressive policies abating. Some principles of the "welfare reforms" were initially instigated under the New Labour government, including the 'workfare' style reforms such as the 'welfare to work' schemes. However under the coalition, and subsequent majority-led conservative government, we have seen an intensification of these processes and an intensification of the social damage that they are wreaking on society. Whilst the prime minister argues for the need to improve social mobility in the UK, affirming that her government will continue to remain 'on the side' of the poorest (May, 2016), in reality a continuation of the policies that were set in place by her predecessors is likely to lead to growing inequalities, and lives that are even further separated by social division.

The damage caused by the austerity programme has been clearly demonstrated throughout this thesis, and a continuation of these practices is likely to have a significant impact both on social inequality, and on inequalities in mental health. A central finding of this project is that issues relating to poverty and deprivation are central determinants of poor mental health: financial hardship has an incredibly damaging impact. People on the lowest incomes are faced with daily – and often insurmountable – challenges in meeting even the most basic of needs. Life on a low income creates chronic stress; this has a significant impact on people's mental health and wellbeing. In continuing with policies that regressively target those on the lowest incomes, this is likely to lead to a widening of the gap in mental health and well-being. Unequal societies are unhealthy ones (Wilkinson and Pickett, 2010): it is only by addressing

social inequality, and raising the living standards of those on the lowest incomes, that inequalities in mental health can begin to narrow.

Despite this negative outlook, this thesis has also shown that people will do what they can to manage. Throughout, we have seen examples of how people will find ways to cope with the inequalities that are facing them, the financial and emotional strategies they use, how they deal with a lack of power, and how they cope with the adverse life events that have been imposed on them. Although life (for some) has grown much harder in the past few years, they have continued to find ways in which to try to get by. This is testimony to the strength people have in being able to endure hardship, to deal with adversity, and to do what they can to survive.

Appendix A Outputs from the PhD

Peer-reviewed publications arising from the thesis

Mattheys, K. (2015) The coalition, austerity and mental health. *Disability & Society* 30 (3): 475-478

Mattheys, K., Bambra, C., Warren, J., Kasim, A., and Akhter, N. (2016) Inequalities in mental health and well-being in a time of austerity: Baseline findings from the Stockton-on-Tees cohort study. *Social Science & Medicine Population Health* 2: 350-359

Conference proceedings and presentations

Mattheys, K. (2014) Austerity and Mental Health in Stockton-on-Tees. Fuse Centre for Translational Research, Newcastle University, Feb 3rd

Mattheys, K. (2014) Exploring Inequalities in Mental Health. Social Work Student Conference, Nottingham Trent University, May 13th

Mattheys, K. (2014) Austerity, Inequality and Mental Health. Annual Conference of First Year Postgraduate Research, Department of Geography, Durham University, May 15th

Mattheys, K. (2014) Using a mixed methods approach to explore inequalities in mental health. Qualitative Health Research Methods Challenge, Durham University, July 4th

Mattheys, K. (2014) Austerity, Inequality and Mental Health. Disability Studies Conference, Lancaster University, September 9th-11th

Mattheys, K. (2015) The Coalition, austerity and mental health. North-East Mad Studies Forum, Durham University, March 12th

Mattheys, K. (2015) Austerity, Inequality and Mental Health. Wolfson Research Colloquium, April 15th

Mattheys, K., Bambra, C., Warren, J., Kasim, A. (2015) Austerity, Inequality and Mental Health: Baseline Findings from the Stockton-on-Tees Survey. Austerity Symposium, Department of Geography, Durham University, May 14th-15th

Mattheys, K., Bambra, C., Warren, J., Kasim, A. (2015) Place, Austerity and Inequalities in Mental Health: A case study from Northern Britain. International Medical Geography Symposium, Simon Fraser Institute, Vancouver, Canada, July 15th

Mattheys, K., Warren, J., Bambra, C., Kasim, A. (2015) Local Health Inequalities in an Age of Austerity: the Stockton-on-Tees Study. Catalyst Conference, Stockton-on-Tees October 29th

Mattheys, K. (2016) Place, Austerity and Inequalities in Mental Health: A case study of Stockton-on-Tees. Department of Geography 3rd Year Conference, Durham University, March 9th

Mattheys, K. (2016) *'They're playing god with you':* Austerity and mental health in Stockton-on-Tees. ENRGHI Conference, Glasgow University, June 16th-17th

Appendix B Methodology

Grid for Selecting Individuals

Assigned Number of Address	Total Number of Eligible Persons					
	1	**2**	**3**	**4**	**5**	**6 or more**
1 or 2	1	1	2	2	3	3
3	1	2	3	3	3	5
4 or 5	1	2	3	4	5	6
6	1	1	1	1	2	2
7 or 8	1	1	1	1	1	1
9	1	2	3	4	5	5
10 or 11	1	2	2	3	4	4
12	1	1	1	2	2	2

Source: Hoinville et al., 1977:82

Construction of Variables in the Survey/Quantitative Analysis

Identification of Mental Health Problems - people with mental health problems were identified by the following question: 'Do you have any long-standing illness, disability or infirmity? By long-standing I mean any physical or mental health problems that have troubled you over a period of time, or that are likely to affect you over a period of time? Please specify'.

Household Receipt of Benefit – incorporated all benefits including those in receipt of state pension and child benefit. This was to show the numbers of people who were in receipt of any form of social security.

Unemployed - included individuals of working age who were not in employment, including those classed as unemployed, unable to work due to ill-health or disability, or looking after the home or family.

Job Skill Type – the Registrar General's classification system (pre-2000) was used as this was felt to be the most commonly used terminology. Job types were coded as: professional; intermediate; skilled non-manual; skilled manual; semi-skilled; unskilled; not working.

Workless Household – defined as households where there were no adults who were in employment, training or education.

Weekly Alcohol Consumption – participants completed a weekly alcohol grid to identify numbers of units of alcohol consumed.

Household Income –incorporated income from all sources i.e. wages, pensions and benefits after tax (net).

Material Physical Environment – participants were asked yes/no questions about whether the home had problems with damp, dark, noise, and was warm enough in winter. They were asked (yes/no) if the neighbourhood had problems with pollution, grime or environmental problems, and if there was crime.

Loneliness – participants were asked how often they lacked companionship, felt left out, and felt isolated from others – answers were either hardly ever, some of the time, or often.

Happiness – participants were asked 'Taking all things together, on a scale of 0-10, where 0 = extremely unhappy and 10 = extremely happy, how happy would you say you are?'

Neighbourhood Safety Perception – Participants were asked 'How safe would you feel walking alone in the neighbourhood after dark?' Answers included either very safe, safe, unsafe or very unsafe. This was included as a psychosocial variable to account for the possible difference between perception of safety and actual safety.

Physical Exercise – Participants were asked how often they do exercise/physical activities – every day/most days/a couple of times a week/once a week/less than once a week/never.

Consent Form

It is important that only people who want to do so participate in this study. You should also be aware that you do not need to answer any particular question and that you may withdraw from the research at anytime you wish.

Please tick the box to indicate you agree with the following statements:

The study has been explained to me. ☐

I understand that my participation is voluntary and that I am free to withdraw from the research at any time. ☐

I understand that the answers I give will be recorded. ☐

The information I give will be used in the final report and any subsequent academic publications arising from the study. ☐

I understand that only the researchers and research secretary will Have access to the information I give and that the information will be anonymised and stored securely. ☐

I understand the above information and agree to participate in this study

_____
Participant signature   Date

_____
Researcher signature   Date

Information Sheet: Survey

Study of Health and Health Inequalities in Stockton-on -Tees

We are researchers from Durham University who are undertaking a survey of the health. The research wants to find out what the impact of government policy, especially spending and welfare cuts are having on living standards of households and the health of individuals. In order to do this we are collecting information from 750 households in the borough of Stockton –on- Tees.

This will involve talking to a researcher on a one to one basis who will visit you in your home. They will ask some questions about your household and everyone who lives there. They will then select one of the adults in the household to ask about their personal situation, any health issues they many have and ask them to complete some further health assessment questions. This will take no longer than 60 minutes

We will contact the same individual to ask the health questions again after 6 months, one year, two years and three years in order to see whether their health has improved, stayed the same or got worse over the time period. We will do this over the telephone and it will take no longer than 30 minutes.Anyone can of course refuse to answer any question that they wish to, or opt out of the research altogether at any point.

All information given will remain completely confidential. We will be recording your answers. However, you will not be identified by name and none of the information you give will be passed to anyone outside of the research team.

All participating households will receive a £10 high street shopping voucher to thank them for their time and help

If you would like any further information, please get in touch with Jon Warren on jonathan.warren@durham.ac.uk or 0191 334082

Information Sheet: Qualitative Interviews

Study of the Impact of Austerity in Stockton-on -Tees

I am a PhD research student from Durham University undertaking a study around the impact of austerity on mental health in Stockton on Tees. The research wants to find out what the impact of government policy, especially spending and welfare cuts, is having on people who report having mental health problems, what the challenges are and how people cope. In order to do this I am undertaking interviews with a range of people in the borough of Stockton –on- Tees.

This will involve talking to me on a one to one basis. I will visit you in your home. I will ask some questions about you including: details such as your marital status and family circumstances; current/previous employment, training and education; welfare benefits, any recent changes to benefits and how this has affected you. I will also ask about the type of support you have received around your mental health and your experiences of this, and what kind of support you think would be helpful. I will ask about your physical health, coping strategies and support networks, and some questions about your neighbourhood and Stockton-on-Tees and how you feel about living there.

The interview should take around 60 minutes and I will be recording your answers. However all information given will remain completely confidential. You will not be identified by name and none of the information you give will be passed to anyone outside of the research team.   If there are any questions that you do not want to answer then you can refuse to answer them, and you can also opt out of the research altogether at any point you choose.

All participating individuals will receive a £10 high street shopping voucher to thank them for their time and help.

If you would like any further information, please get in touch with either myself, Kate Mattheys, on kate.mattheys@durham.ac.uk or my supervisor, Jon Warren, on jonathan.warren@durham.ac.uk.

Appendix C Results

Table 1: Initial Analysis for Mental Health Outcomes and Individual Variables

Explanatory Variable	Test	WEMWBS P-Value	SF8 MCS P-Value
Material Explanations			
Deprived or Affluent LSOA	T-Test	p<0.001	P<0.001
Individual Income	Linear Regression	P=0.010	P=0.010
Is the individual in employment	T Test	P<0.001	P<0.001
Is the household in receipt of benefits	T Test	P<0.001	P<0.001
Housing Tenure	ANOVA	P<0.001	P<0.001
Crime violence and vandalism in the neighbourhood	T Test	P=0.002	P<0.001
Job Skill Type	ANOVA	P=0.924	P=0.519
Is this a workless household	T Test	P<0.001	P<0.001
Is the household in receipt of housing benefit	T Test	P<0.001	P<0.001
Are there problems with damp in the home	T Test	P=0.002	P=0.002
Is the household warm enough?	T Test	P=0.004	P=0.007
Noise from neighbours/street	T Test	P=0.001	P<0.001
Household is too dark	T Test	P<0.001	P<0.001
Pollution in neighbourhood	T Test	P<0.001	P<0.001
Education Level	ANOVA	P=0.000	P<0.001
Household Income	Linear Regression	P<0.001	P<0.001
Fuel Poverty	T Test	P<0.001	P<0.001
Psychosocial Explanations			
Happiness Scale	Linear Regression	P<0.001	P<0.001
Is the individual satisfied with his/her job	ANOVA	P<0.001	P=0.006
Does the individual find his/her work stressful	ANOVA	P=0.160	P=0.026
Job Security	ANOVA	P<0.001	P=0.011
Levels of feeling isolated from others	ANOVA	P<0.001	P<0.001
How often feel left out	ANOVA	P<0.001	P<0.001
How often lack companionship	ANOVA	P<0.001	P<0.001
How often the individual meets socially with friends, family or work colleagues	ANOVA	P<0.001	P=0.048
How safe feel walking alone after dark	ANOVA	P<0.001	P<0.001

Behavioural Explanations

Alcohol units per week	Linear Regression	P=0.282	P=0.722
Alcohol use yes/no	T Test	P<0.001	P<0.001
Fruit and veg intake per week	Linear Regression	P<0.001	P=0.001
Smoking yes/no	T Test	P<0.001	P=0.001
Body Mass Index	Linear Regression	P=0.001	P<0.001
Amount of weekly exercise (minutes)	Linear Regression	P=0.441	P=0.731
Frequency of Physical exercise	ANOVA	P<0.001	P=0.113
Other Variables			
Age	Linear Regression	P=0.179	P=0.156
Gender	T Test	P=0.292	P=0.018
Does individual report a mental health problem	T Test	P<0.001	P<0.001
Does individual report a long standing health problem	T Test	P<0.001	P<0.001
Is the individual a carer	T Test	P=0.922	P=0.383
Multiple Health Problems	T Test	P<0.001	P<0.001

Table 2: Data Cleaning Process for WEMWBS and SF8 MCS Analysis

Variable	Problem	Action Taken
Damp	1 missing	Deleted Case
Warm	1 missing	Deleted Case
Household Income	71 missing	Deleted Cases
Job Skill level	536 missing	Deleted variable from analysis
Individual Income	57 missing	Deleted variable from analysis
Education	1 missing	Deleted Case
Fuel Poverty	124 missing	Deleted variable
Job security	535 missing	Deleted variable
Job stress	535 missing	Deleted variable
Job satisfaction	535 missing	Deleted variable
Social meeting frequency	1 missing	Deleted case
Lacking companionship	1 missing	Deleted case
Safety perception	19 missing	Deleted cases
Feeling left out	1 missing	Deleted case
Feeling isolated	1 missing	Deleted case
Happiness scale	1 missing	Deleted case
Alcohol units	3 missing	Deleted cases
Fruit and veg intake	6 missing	Deleted cases
BMI	38 missing	Deleted variable
Weekly Exercise in mins	11 missing	Deleted variable
SF8 scores	3 missing	Deleted cases

Model Building Process WEMWBS

Model 1: Initial Model all Variables

Type III Tests of Fixed Effects[a]

Source	Numerator df	Denominator df	F	Sig.
Intercept	1	706.000	89.849	.000
SEX	1	706	.609	.435
AGE	1	706.000	.159	.691
DEPRIVATION	1	706	.004	.947
HOUSINGTENURE	3	706	3.263	.021
HOUSEHOLDBENEFITS	1	706.000	2.095	.148
HOUSINGBENEFIT	1	706	7.074	.008
EMPLOYMENT	1	706.000	.156	.693
WORKLESSHOUSEHOLD	1	706.000	.096	.756
HOUSEHOLDDAMP	1	706	1.139	.286
HOUSEHOLDDARK	1	706.000	3.755	.053
HOUSEHOLDWARMTH	1	706.000	4.265	.039
NEIGHBOURHOODNOISE	1	706	1.024	.312
POLLUTION	1	706	6.386	.012
CRIME	1	706	.010	.919
SMOKING	1	706.000	2.874	.090
ALCOHOL	1	706.000	13.607	.000
HOUSEHOLDINCOME	1	706	6.183	.013
EDUCATIONLEVEL	1	706	2.383	.123
SOCIALMEETING	1	706.000	.517	.472
SAFETYPERCEPTION	1	706	2.918	.088
LACKCOMPANIONSHIP	1	706	.007	.934
LEFTOUT	1	706.000	6.215	.013
ISOLATED	1	706.000	1.801	.180
HAPPINESSSCALE	1	706.000	166.048	.000
ALCOHOLUNITS	1	706.000	.356	.551
FRUITANDVEG	1	706	.692	.406
EXERCISE	1	706.000	13.352	.000

Model 2: Variables removed where p>0.500 (taking out employment, workless household, crime, lacking companionship, alcohol units)

Type III Tests of Fixed Effects[a]

Source	Numerator df	Denominator df	F	Sig.
Intercept	1	711	92.930	.000
SEX	1	711.000	.800	.372
AGE	1	711	.212	.645
DEPRIVATION	1	711.000	.003	.959
HOUSINGTENURE	3	711	3.356	.019
HOUSEHOLDBENEFITS	1	711	2.114	.146
HOUSINGBENEFIT	1	711	7.766	.005
HOUSEHOLDDAMP	1	711	1.178	.278
HOUSEHOLDDARK	1	711	3.787	.052
HOUSEHOLDWARMTH	1	711.000	4.229	.040
NEIGHBOURHOODNOISE	1	711	1.154	.283
POLLUTION	1	711	6.598	.010
SMOKING	1	711	3.063	.081
ALCOHOL	1	711.000	14.085	.000
HOUSEHOLDINCOME	1	711	6.738	.010
EDUCATIONLEVEL	1	711	2.453	.118
SOCIALMEETING	1	711	.559	.455
SAFETYPERCEPTION	1	711.000	2.851	.092
LEFTOUT	1	711.000	6.914	.009
ISOLATED	1	711.000	1.927	.165
HAPPINESSSCALE	1	711	177.398	.000
FRUITANDVEG	1	711	.682	.409
EXERCISE	1	711	14.051	.000

a. Dependent Variable: WEMWBS total score.

Model 3: Variables removed where p>0.200 (taking out household damp, neighbourhood noise, social meeting, fruit and vegetables)

Type III Tests of Fixed Effects[a]

Source	Numerator df	Denominator df	F	Sig.
Intercept	1	715.000	108.774	.000
SEX	1	715.000	.704	.402
AGE	1	715.000	.141	.708
DEPRIVATION	1	715	.024	.877
HOUSINGTENURE	3	715.000	3.247	.021
HOUSEHOLDBENEFITS	1	715.000	2.054	.152
HOUSINGBENEFIT	1	715.000	7.416	.007
HOUSEHOLDDARK	1	715	3.257	.072
HOUSEHOLDWARMTH	1	715.000	3.544	.060
POLLUTION	1	715	5.067	.025
SMOKING	1	715.000	3.389	.066
ALCOHOL	1	715	13.807	.000
HOUSEHOLDINCOME	1	715.000	6.701	.010
EDUCATIONLEVEL	1	715.000	2.258	.133
SAFETYPERCEPTION	1	715.000	2.442	.119
LEFTOUT	1	715.000	6.477	.011
ISOLATED	1	715.000	1.959	.162
HAPPINESSSCALE	1	715	177.171	.000
EXERCISE	1	715	15.387	.000

a. Dependent Variable: WEMWBS total score.

Model 4: Variables removed where p>0.100 (taking out household benefits, education level, safety perception, isolated)

Type III Tests of Fixed Effects[a]

Source	Numerator df	Denominator df	F	Sig.
Intercept	1	719.000	117.030	.000
SEX	1	719	.187	.666
AGE	1	719.000	.219	.640
DEPRIVATION	1	719.000	.081	.776
HOUSINGTENURE	3	719.000	3.766	.011
HOUSINGBENEFIT	1	719	10.026	.002
HOUSEHOLDDARK	1	719.000	2.610	.107
HOUSEHOLDWARMTH	1	719	4.533	.034
POLLUTION	1	719	5.533	.019
SMOKING	1	719	2.894	.089
ALCOHOL	1	719.000	15.086	.000
HOUSEHOLDINCOME	1	719	8.495	.004
LEFTOUT	1	719.000	22.037	.000
HAPPINESSSCALE	1	719.000	217.932	.000
EXERCISE	1	719	14.079	.000

a. Dependent Variable: WEMWBS total score.

Model 5: Variables removed where p>0.05 (taking out household dark, smoking)

Type III Tests of Fixed Effects[a]

Source	Numerator df	Denominator df	F	Sig.
Intercept	1	721.000	119.945	.000
SEX	1	721	.161	.689
AGE	1	721	.515	.473
DEPRIVATION	1	721	.003	.960
HOUSINGTENURE	3	721	3.441	.017
HOUSINGBENEFIT	1	721.000	10.146	.002
HOUSEHOLDWARMTH	1	721	4.508	.034
POLLUTION	1	721	5.782	.016
ALCOHOL	1	721.000	15.977	.000
HOUSEHOLDINCOME	1	721	9.682	.002
LEFTOUT	1	721	22.588	.000
HAPPINESSSCALE	1	721	223.782	.000
EXERCISE	1	721	13.662	.000

a. Dependent Variable: WEMWBS total score.

Log Likelihood Ratio Testing WEMWBS Models

	Number of Levels	2 Restricted Log Likelihood	Difference in log ratio	Difference df	p value
Model 1	45	5191.98			
Reduced Model 2	37	5193.54	1.56	8.00	0.99
Reduced Model 3	31	5197.76	4.22	6.00	0.65
Reduced Model 4	26	5208.21	10.45	5.00	0.06
Reduced Model 5	22	5216.88	8.66	4.00	0.07

Identifying the Suppressor Variables in the WEMWBS Model

Reduced Model	Number Levels	2 Restricted Log Likelihood	Difference LL	Difference df	P value
Without Household Benefits	20	5228.93	12.056	2.00	0.002
Without Household Income	21	5223.12	6.250	1.00	0.012
Without Household Warm	20	5223.13	6.263	2	0.04
Without Pollution	20	5224.81	7.940	2	0.019
Without Left Out	21	5239.96	23.085	1	<0.001
Without Alcohol	20	5233.86	17.0	2	<0.001

Final Model WEMWBS

Estimates of Fixed Effects[a]

Parameter	Estimate	Std. Error	df	T	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Intercept	28.812	2.600	722	11.081	.000	23.707	33.916
SEX	-.192	.659	722	-.291	.771	-1.486	1.103
AGE	.018	.022	722	.842	.400	-.0245	.0615
DEPRIVATION	.073	.875	722	.084	.933	-1.644	1.790
HOUSING TENURE own outright	-1.484	1.177	722	-1.260	.208	-3.796	.828
HOUSING TENURE mortgage	-3.131	1.167	722	-2.683	.007	-5.421	-.840
HOUSINGTENURE live rent free	3.342	3.602	722	.928	.354	-3.730	10.414
HOUSING BENEFIT	-3.213	1.066	722	-3.014	.003	-5.305	-1.120
POLLUTION	-2.936	1.185	722	-2.479	.013	-5.262	-.611
ALCOHOL	2.829	.717	722	3.945	.000	1.421	4.237
HOUSEHOLDINCOME	.237	.074	722	3.214	.001	.0922	.381
LEFTOUT	-2.936	.599	722	-4.901	.000	-4.112	-1.760
HAPPINESSSCALE	2.887	.189	722	15.275	.000	2.516	3.258
EXERCISE	.558	.156	722	3.574	.000	.252	.865

a. Dependent Variable: WEMWBS total score.
b. This parameter is set to zero because it is redundant.

Model Building Process SF8 MCS

Model 1 Initial Model All Variables

Type III Tests of Fixed Effects[a]

Source	Numerator df	Denominator df	F	Sig.
Intercept	1	736.000	221.430	.000
SEX	1	736	1.746	.187
AGE	1	736.000	.992	.320
DEPRIVATION	1	736.000	.000	.989
HOUSINGTENURE	3	736.000	.472	.702
HOUSEHOLDBENEFITS	1	736	.001	.971
HOUSINGBENEFIT	1	736	.004	.949
EMPLOYMENT	1	736	.950	.330
WORKLESSHOUSEHOLD	1	736	.204	.651
HOUSEHOLDDAMP	1	736.000	.002	.964
HOUSEHOLDDARK	1	736.000	8.052	.005
HOUSEHOLDWARMTH	1	736.000	.234	.629
NEIGHBOUROODNOISE	1	736	.073	.788
POLLUTION	1	736	2.256	.134
CRIME	1	736	1.958	.162
SMOKING	1	736.000	.004	.949
ALCOHOL	1	736.000	4.780	.029
HOUSEHOLDINCOME	1	736.000	.008	.928
EDUCATIONLEVEL	1	736.000	1.512	.219
SOCIALMEETING	1	736.000	2.150	.143
SAFETYPERCEPTION	1	736.000	5.023	.025
LACKCOMPANIONSHIP	1	736	4.042	.045
LEFTOUT	1	736.000	9.163	.003
ISOLATED	1	736.000	5.020	.025
HAPPINESSSCALE	1	736.000	78.862	.000
ALCOHOLUNITS	1	736.000	.205	.651
FRUITVEG	1	736.000	.482	.488
EXERCISE	1	736.000	.377	.539

a. Dependent Variable: SF8 Mental Health Final Value.

Model 2: Variables removed where p>0.500 (removing housing tenure, household benefits, household housing benefit, workless household, household damp, household warm, neighbourhood noise, smoking, household income, alcohol units, exercise)

Type III Tests of Fixed Effects[a]

Source	Numerator df	Denominator df	F	Sig.
Intercept	1	736.000	305.361	.000
SEX	1	736	1.893	.169
AGE	1	736.000	1.027	.311
DEPRIVATION	1	736.000	.004	.950
EMPLOYMENT	1	736	3.005	.083
HOUSEHOLDDARK	1	736.000	8.293	.004
POLLUTION	1	736	2.705	.100
CRIME	1	736	2.144	.144
ALCOHOL	1	736.000	4.970	.026
EDUCATIONLEVEL	1	736.000	1.616	.204
SOCIALMEETING	1	736.000	2.199	.139
SAFETYPERCEPTION	1	736.000	5.316	.021
LACKCOMPANIONSHIP	1	736.000	4.373	.037
LEFTOUT	1	736	9.448	.002
ISOLATED	1	736	5.022	.025
HAPPYSCALE	1	736.000	83.141	.000
FRUITVEG	1	736	.607	.436

a. Dependent Variable: SF8 Mental Health Final Value.

Model 3: Variables removed where p>0.200 (removing education level, fruit and vegetables)

Type III Tests of Fixed Effects[a]

Source	Numerator df	Denominator df	F	Sig.
Intercept	1	736	332.299	.000
SEX	1	736	1.509	.220
AGE	1	736.000	.351	.554
DEPRIVATION	1	736.000	.079	.779
EMPLOYMENT	1	736	2.730	.099
HOUSEHOLDDARK	1	736	8.260	.004
POLLUTION	1	736	2.697	.101
CRIME	1	736	2.074	.150
ALCOHOL	1	736	4.559	.033
SOCIALMEETING	1	736.000	2.188	.139
SAFETYPERCEP	1	736.000	5.334	.021
LACKCOMPANIONSHIP	1	736	4.171	.041
LEFTOUT	1	736.000	9.898	.002
ISOLATED	1	736	4.813	.029
HAPPYSCALE	1	736	86.170	.000

a. Dependent Variable: SF8 Mental Health Final Value.

Model 4: Variables removed where p>0.100 (removing crime, social meeting)

Type III Tests of Fixed Effects[a]

Source	Numerator df	Denominator df	F	Sig.
Intercept	1	736	373.230	.000
SEX	1	736	1.509	.220
AGE	1	736	.245	.621
DEPRIVATION	1	736.000	.016	.900
EMPLOYMENT	1	736	3.119	.078
HOUSEHOLDDARK	1	736	8.402	.004
POLLUTION	1	736	4.062	.044
ALCOHOL	1	736	4.295	.039
SAFETYPERCEPTION	1	736	5.960	.015
LACKCOMPANIONSHIP	1	736	4.531	.034
LEFTOUT	1	736.000	9.605	.002
ISOLATED	1	736.000	4.309	.038
HAPPINESSSCALE	1	736.000	86.732	.000

a. Dependent Variable: SF8 Mental Health Final Value.

Model 5: Variables removed where p>0.05

Type III Tests of Fixed Effects[a]

Source	Numerator df	Denominator df	F	Sig.
Intercept	1	736	385.747	.000
SEX	1	736	1.631	.202
AGE	1	736.000	1.703	.192
DEPRIVATION	1	736	.325	.569
HOUSEHOLDDARK	1	736.000	8.478	.004
POLLUTION	1	736	4.119	.043
ALCOHOL	1	736	5.457	.020
SAFETYPERCEPTION	1	736.000	5.843	.016
LACKCOMPANIONSHIP	1	736	4.127	.043
LEFTOUT	1	736.000	10.272	.001
ISOLATED	1	736	4.622	.032
HAPPINESSSCALE	1	736	87.237	.000

a. Dependent Variable: SF8 Mental Health Final Value.

Log Likelihood Ratio Testing SF8 MCS Models

	Number of Levels	2 Restricted Log Likelihood	Difference in log ratio	Difference df	p value
Model 1	45	5127.815092			
Reduced Model 2	24	5130.459863	2.64477	21	1
Reduced Model 3	22	5132.422742	1.96288	2	0.37
Reduced Model 4	19	5136.69254	4.2698	3	0.23
Reduced Model 5	17	5139.804539	3.112	2	0.21

Final Model SF8 MCS

Estimates of Fixed Effects[a]

Parameter	Estimate	Std. Error	df	t	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Intercept	46.492	2.475	736	18.783	.000	41.632	51.351
SEX	.769	.626	736	1.229	.220	-.460	1.997
AGE	-.009	.0187	736	-.495	.621	-.046	.027
DEPRIVATION	.0850	.675	736	.126	.900	-1.241	1.411
EMPLOYMENT	1.227	.695	736	1.766	.078	-.137	2.591
HOUSEHOLDDARK	-2.584	.892	736	-2.899	.004	-4.334	-.834
POLLUTION	-2.232	1.108	736	-2.015	.044	-4.407	-.058
ALCOHOL	1.397	.674	736	2.073	.039	.0737	2.719
SAFETYPERCEPTION	-.903	.370	736	-2.441	.015	-1.629	-.177
LACKCOMPANIONSHIP	-1.453	.683	736	-2.129	.034	-2.793	-.113
LEFTOUT	-2.463	.795	736	-3.099	.002	-4.023	-.903
ISOLATED	-1.661	.800	736	-2.076	.038	-3.232	-.090
HAPPINESSCALE	1.759	.189	736	9.313	.000	1.388	2.130

a. Dependent Variable: SF8 Mental Health Final Value.
b. This parameter is set to zero because it is redundant.

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