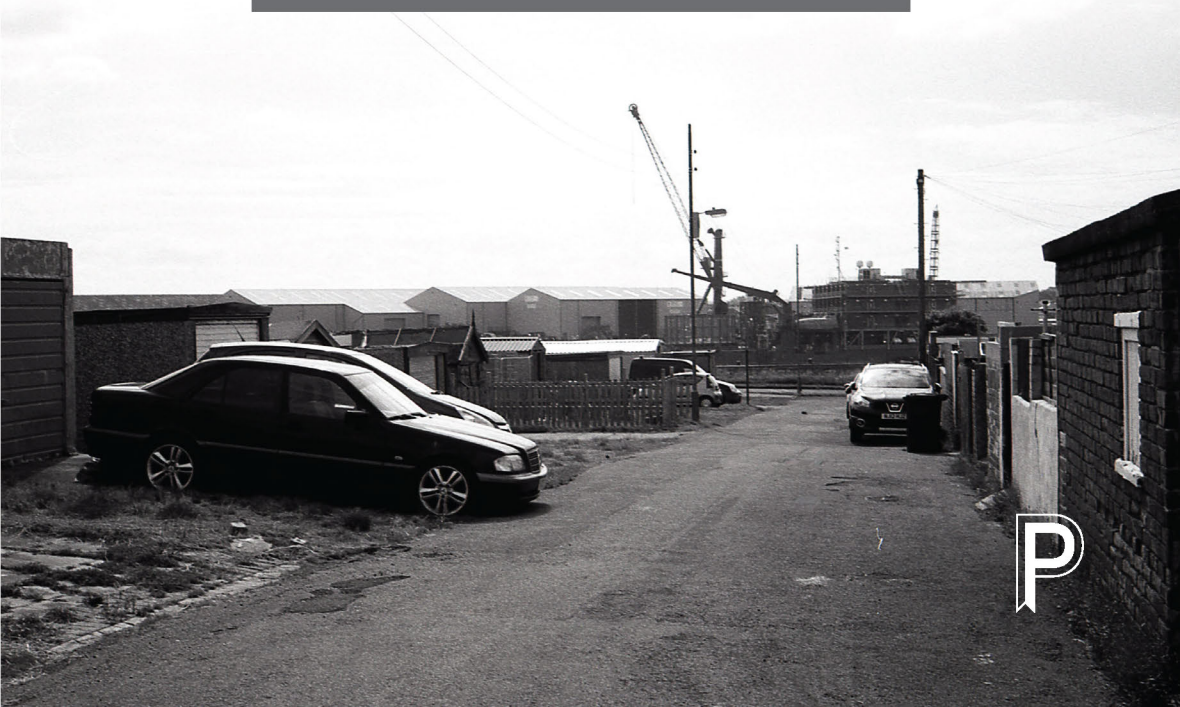
Health in Hard Times

Austerity and Health Inequalities

Edited by
Clare Bambra



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Bristol
BS2 8BB
UK
t: +44 (0)117 954 5940
pp-info@bristol.ac.uk
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f: +1 773-702-9756
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FIVE

Divided Lives

Kate Mattheys

Introduction

This chapter considers how inequalities in mental health are affected by austerity, providing a qualitative account of the *human price* of government policy. Engaging with debates about inequalities in mental health, it uses interview data from people experiencing mental health problems in the most and the least deprived neighbourhoods of Stockton-on-Tees, to show how people experience austerity and inequality in their everyday lives. Austerity measures are shown to have a damaging impact on communities in the most deprived areas while leaving those from less deprived areas relatively unscathed. It documents how people's lived experiences have been shaped by austerity, and how long-standing structural inequalities have been compounded by deeply regressive policies which are shown to be having a damaging impact on the mental health of those affected by them, causing a chronic level of stress that has a relentless influence on their everyday lives. Although government rhetoric highlighted how we were 'all responsible' for fixing the national debt, this chapter shows how it is those on the lowest incomes and living in the most deprived communities who are paying the highest price.

While dealing with mental health problems was challenging for everybody in this study (regardless of their background and the areas they came from), there were key differences in their lives and in the day-to-day difficulties that they faced. These included differences in income and financial stability, employment and the environments that people were living in. All were discussed in relation to their impacts on mental health. Austerity, and in particular the 'welfare reform' programme, are shown to have disproportionately affected those living in the most deprived areas. This is because austerity has been regressive, overwhelmingly targeting those on the lowest incomes (Hills, 2014). The impact of these cuts has been pervasive, cutting across people's financial, emotional and social lives. For those already

dealing 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. This is aggravating inequalities in mental health in a place which already had the highest health inequalities in England Public Health England (2015).

Background

Mental health follows a social gradient in the same way as physical health (Marmot, 2010). The higher a household's income, the lower the likelihood of the individual in that household having mental health problems (McManus et al., 2009). We are not all equally likely to experience poor mental health. There is a strong evidence base for the link between mental health and material deprivation, low income and socioeconomic status (Williams, 2002; Melzer et al., 2009). The effects of living in poverty, including the impact of low income, debt, unemployment, poor working conditions (including insecure employment and zero hours contracts), housing, and living in areas with high levels of deprivation can all have negative impacts on people's mental health (Rogers and Pilgrim, 2003). Additionally, people who are experiencing mental distress are at increased risk of poverty, due, for instance, to discrimination in the workplace preventing people from being able to secure and maintain employment (Evans-Lacko et al., 2013). Between 30% and 40% of people who report having mental health problems such as depression or anxiety in England are not in employment (Mental Health Taskforce, 2016), while between 85% and 95% of people who have been labelled with schizophrenia are not in paid work (NICE, 2015). Some people are unable to work as a result of their mental and physical health. Discrimination and a lack of appropriate employment opportunities also play a role. When people with mental health problems are in employment, they are over-represented in insecure, low-paid work (Mental Health Taskforce, 2016). These types of precarious jobs have been shown to have as damaging an impact on mental health as being out of work (Kim and von dem Knesebeck, 2015).

Despite strong links between social inequality and mental health, in the past 30 years the dominant position in public health has been to adopt approaches that focus solely on the individual (Morrow, 2013). These approaches are pathologising and ignore the wider contexts in which people are living (Beresford, 2005). Despite clear research linking mental health problems to intersecting social and structural inequalities such as poverty and racism, these social and

structural determinants are often marginalised (Morrow, 2013). Social perspectives provide an alternative to the dominant medical models. Although there is no clear definition of a social model of mental health (Tew, 2005), these approaches recognise the role of broader social and environmental factors (Beresford et al., 2010). This includes, for instance, the impact of income, employment and the environments in which people are living. Social models of mental health do not position people as outsiders with abnormal experiences, but instead as people who are responding to experiences and trauma in their lives. 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 contribute to poor mental health.

Since 2010, research at a national level has shown that inequalities in mental health (the gap in mental health between people from different socioeconomic backgrounds and between people from more and less deprived areas) has worsened in the UK (Barr et al., 2015a). People living in more deprived areas have seen the largest increases in poor mental health (Barr et al., 2015b). Worsening mental health has been linked to the programme of 'welfare reform' that has included numerous and significant cuts in social security. These cuts have led to increasing financial hardship for those on the lowest incomes, and the increasing financial insecurity has affected mental well-being (Barr et al., 2015b). The effects of austerity have not been distributed evenly, either spatially or socially (Bambra and Garthwaite, 2015). The most affected areas have included the older industrial areas such as the North East of England (Beatty and Fothergill, 2016). Further, those on the lowest incomes have been affected most by the cuts in social security as the cuts have fallen most heavily on this group of people (Hills, 2014).

Qualitative studies have identified the negative mental health impact of worsening financial situations and increasing insecurity (Pemberton et al., 2014). Cuts in social security have led to chronic worry, stress and anxiety for people (Patrick, 2015), and this stress created by the social security system has been reported as an endless and unremitting pressure (Garthwaite et al., 2015). This has been accompanied by damning political and media portrayals of people who are in receipt of out-of-work and ill-health-related benefits (Pemberton et al., 2014). This includes people increasingly positioned as to blame for being unable to work, with a divisive rhetoric applied between the 'shirkers' and 'strivers' (Garthwaite, 2011). Within this context we have seen

the rise of the so-called 'poverty porn' programmes on television, including 'Benefits Street', 'Benefits Britain: Life on the Dole' and the 'The Great British Benefits Handout'. Overwhelmingly these shows portray people in a negative light. Such critical depictions have been found to have a damaging impact on mental health (Garthwaite, 2014).

This chapter will present findings from qualitative research exploring differences in the lives and the experiences of austerity among people with mental health problems living in more and less deprived areas of Stockton-on-Tees. Although there is a social gradient in mental health, experiences of mental health problems still exist across the social spectrum. People's experiences of austerity are likely to be different between those from different socioeconomic backgrounds (Bambra, 2016). The interviews explored these differences in experience. Alongside the inequalities that are the focus of this chapter, it is important to acknowledge that other experiences were also discussed during the interviews. People talked about the importance of traumatic experiences – such as abuse, grief and loss – they had faced in their lives and which they felt contributed towards their experiences of mental distress. However, 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 inequalities in their lives and their relationship with mental health is the focus of this chapter. A key point is that dealing with complex and multiple issues compounded the challenges faced by some of the people in the study. So, some were not only dealing with mental health problems, they also faced the challenges of managing on a reduced income, of being unable to work and of 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 the difficulties faced by those on low incomes. While participants from all of the groups had experienced difficulties with their mental health, 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.

Methodology

This research developed out of the findings from the longitudinal household survey exploring inequalities in physical and mental health between people from the most and least deprived areas of Stockton-

on-Tees (discussed in Chapter Six). Qualitative semi-structured interviews were undertaken with people from the survey who self-identified as having mental health problems. Additional interviews were undertaken with people with mental health problems who were accessing support from the local Citizens Advice Bureau (CAB), in order to capture the specific experiences of people who were being supported with welfare advice. The participants in the survey who self-reported as having mental health problems formed the sampling frame of participants to take part in the semi-structured interviews. A sample of 17 participants, mixed between those from the most and least deprived areas of Stockton-on-Tees and the CAB was drawn to undertake further interviews, using a theoretical sampling approach. There were ten women and seven men in the sample. Five participants were recruited from the most and seven from the least deprived areas of Stockton-on-Tees, and five participants from the CAB. Ages ranged between 27 and 62 years, although the majority of participants were in their forties and fifties. In the most deprived/CAB groups, two participants were in paid employment, two participants were in receipt of Job Seeker's Allowance (JSA); six participants received either Employment and Support Allowance (ESA) or Incapacity Benefit (IB); and four participants received Disability Living Allowance (DLA)/Personal Independence Payments (PIP). In the least deprived group, four participants were in paid employment, one participant was in receipt of JSA, and two participants were recently retired. The interviews took place in a six-month period between March and September 2015. A thematic analysis was used to interpret the findings.

Findings: inequality and mental health

In this section, key themes around the relationship between material inequalities and mental health are explored. First, the impact of increasing financial hardship in the more deprived areas is discussed. This is then contrasted with the relatively comfortable financial situations of those in the least deprived areas. People's experiences of the impact of austerity on their day-to-day lives are explored, including the impact of the social security system, and the cuts, on mental health. The differences in people's experiences of employment and the relationship between employment and physical and mental health are explored. The chapter concludes by considering the impact of different living environments – the role of place – on mental health.

Increasing hardship: struggling to get by in the more deprived areas

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

Materialist explanations of health inequalities focus on the impacts of poverty, relative deprivation and processes of social exclusion on health outcomes (including mental health) and life expectancy (Shaw et al., 2006). They link income, and lack of resources and power, to the continuing gap in health. There were large differences in the financial situations of people from the least deprived areas, those from the most deprived areas and CAB. The participants from the most deprived areas talked about their material circumstances as having worsened significantly in recent years. Financial insecurity was a significant issue in people's lives; they talked about the challenges in trying to get by and the ongoing stress.

Between 2010 and 2015, people on low incomes faced worsening material circumstances across the UK (MacInnes et al., 2015). Increases in the cost of living (including the cost of food, fuel and rent) have had a more substantial impact on people on low incomes, as these items represent a much larger proportion of expenditure. Almost a fifth of the population is now unable to afford three or more items from a list of everyday items such as a washing machine, car or a healthy meal (MacInnes et al., 2015). Paul was a 27-year-old man who lived with his partner in a socially rented flat. He had grown up in Stockton-on-Tees and had strong ties to the area. Paul had type 1 diabetes and mental health problems and was not currently able to work as a result of his ill-health. He described the struggle of getting by day to day. Paying for even basic bills, such as heating and electricity, was a weekly challenge:

> '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 [electricity] runs out and … so you're just going round and round.' (Paul, 27)

For Paul, alongside the other participants in the study, financial worries affected their mental health by increasing levels of stress and anxiety. This increased stress compounded the difficulties that people were

already facing as a result of dealing with mental health problems. The uncertainty of how to make ends meet, and whether they were going to be able to pay their bills that month, or even have enough to buy food had a chronic impact. Generally it was the participants who were reliant on out-of-work or ill-health-related benefits who were in the most difficult financial situations. However there were also participants employed in low-paid jobs who were struggling to cope financially. This reflects increasing levels of in-work poverty in the UK: a record high of 55% of people in poverty are now in working households (JRF, 2016). Since 2007/08 household incomes have risen more slowly than prices for virtually everyone in the UK (aside from the wealthiest, who have managed to fare well from the global financial crisis), leading to declining living standards for many (Hirsh, 2015). This is particularly the case for low-income households of working age (Belfield et al., 2015). Claire was a 49-year-old woman who lived with her husband and worked part-time on a minimum wage in a local community centre. She spoke of the day-to-day 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)

The people who were in receipt of either JSA, or ESA, or had been affected by some of the other cuts such as the bedroom tax, were often in challenging financial situations. Laura and her husband were both in receipt of ill-health-related benefits, and had been affected by the bedroom tax and a requirement to now pay council tax. Laura also had a 17-year-old son living at home. While 16–19 years olds from low-income households could previously receive Education Maintenance Allowance (EMA) to attend further education, in 2010 this payment was abolished. Combined, the welfare cuts that the family had experienced were having a really significant impact on their finances. Laura spoke about some of the challenges in getting by on a reduced income.

> 'When me son's at college, we have to pay for him. When me niece went she got about thirty pound a week, but they don't get it now. He walks to college and we give him money for his dinner. And so that's coming out of

> what you get. We only get paid fortnightly, so you find that when you've paid all your bills at the end of it, you're like Oh my god I've only got a hundred pound to live on for a fortnight. You know, it's hard. It's hard to budget your money. You're always looking for the cheapest shop. Where once over you could think Ah right, I'll just go to Asda and do me shopping there, you can't now. Cause you think, a loaf of bread in there's £1.50, I could go to Aldi and get two loaves for that price. So you're dropping between shops, you know.' (Laura, 53)

As with Laura, the people who were struggling financially adopted a variety of methods and strategies to cope with this. Many of these strategies involved 'doing without'. Other findings have identified that managing on benefits involves strategies such as shopping in the reduced aisles in supermarkets, 'shopping around', and pawning items in difficult times (Patrick, 2015). Similar findings are presented here. Participants talked about the cyclical nature of food consumption and having to do without groceries to make sure they were able to pay for other outgoings. Peter had coeliac disease and received some food items on prescription. He talked about the need to make do with what was in the house because he did not have any money to buy food:

> 'Last fortnight was good because I had money for food. This fortnight I don't. So whatever's in the cupboard, and whatever me girlfriend helps us out with, like I get pizza bases off the chemist, and she's going to pick them up for me, I got tomato puree, I got cheese. So that's it, we're having pizza for tea. It's hand to mouth.' (Peter, 47)

Participants also spoke of strategies such as 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. The 'poverty premium' is a term to describe how people on low incomes need to pay more for essential goods and services (Davies et al., 2016). This includes, for instance, the need to use higher-cost credit to buy goods because people do not have the money to buy items outright. As an example of these inflated costs, a washing machine at a well-known high street retailer costs £435 to buy outright. The same washing machine, paid for by weekly instalments over a 3 year period, would cost the customer £975 (at an interest rate of 69.9%). For people who don't have the

savings, or income, to be able to buy these items outright, they often have no choice but to pay these rates:

> '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)

Although people had strategies they used to try and deal with a lack of money, and carefully budgeted their finances, there often simply was not enough to get by. This was a source of significant stress.

Managing comfortably: financial stability in the least deprived areas

Finances were not an issue that came up naturally in the interviews with people in the less deprived areas. While they did not perceive themselves as being 'wealthy', they talked about being comfortable financially. Money was not a source of stress to them. Dennis was a 57-year-old man who lived with his wife in his own home in one of the more affluent areas of Stockton-on-Tees. He 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)

Participants in the least deprived areas used their income to pay for goods and activities that might help their mental health, and that would give them a break from their daily lives. Holidays were discussed as important as they gave people an opportunity to get away and take some 'time out'. Participants also frequently spoke about going on trips out for the day, hobbies, going out for meals and drinks with family and friends. They had the financial means to be able to do this. 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. He could afford to do this. Having enough income also, crucially, gave people the means to resolve situations that were damaging their mental health, such as taking early retirement or dropping down to part-time employment. This was more possible for the participants who were in their fifties and sixties. Dennis had taken early retirement from HM Revenues & Customs (HMRC) as a result of the stress that he had been under at work, and was in a financial situation where he could afford to do this. 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)

This ability – to be able to escape from a harmful work situation – was not an available option to those living in the more deprived areas.

Being dragged down: the negative mental health impacts of the social security system

For those participants who were managing on a low income, a lack of money, and the stress that this caused, was a recurrent theme. The stress involved in not having enough money was particularly present for those who were in receipt of out-of-work or ill-health-related benefits. This was linked to anxiety around not knowing when (or if) benefits were going to be paid, and the ongoing stress around how to get by financially if benefits were not paid. This was presented as a relentless, ongoing stress that people had to contend with. They discussed how when one benefit was stopped, this often had a knock-on effect on other benefits. This uncertainty and relentlessness often aggravated the difficulties that people were already facing with their mental health. Jimmy was a 47-year-old man who lived with his wife and two children. He was in receipt of ill-health-related benefits and talked about the pressure he had been placed under 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 particularly spoken about in relation to ESA and the Work Capability Assessment (WCA), the assessment that tests people's eligibility for this benefit. The WCA was introduced by the previous Labour administration; however, since 2010 its implementation has seen greater conditionality (with significant cuts to eligibility and entitlement) and more stringent medical tests. This is despite ongoing controversy and a five-year review process (Daguerre and Etherington, 2014). 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. Since its initial implementation there has been an ongoing and substantial criticism of the WCA, with arguments that it is both unfair and lacks credibility: nearly 40% of appeals lead to decisions being overturned (Barr et al., 2015a). Mental health charities have repeatedly voiced alarm that the process is damaging people's mental health, concerns which have been supported by academic research finding a link 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 55 years old and lived alone in the town centre. She 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 affecting 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 Jobseeker's 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)

The processes involved in ESA were highlighted as being particularly stressful. Participants talked of a relentless process of failing medicals, challenging decisions, passing the appeals and then being sent for a reassessment within a very short period of time. There was no respite from this. Some participants kept going with this process of assessment and appeals (particularly those who were being given advocacy support), whereas others had felt unable to keep appealing. Andy

talked about the process of assessment for ESA and how, because he had attended the medical on his own, he was seen as able to work and told his was no longer eligible to receive ESA. He had tried to appeal but "gave up" in the end, despite feeling this was the wrong decision:

> 'I was on ESA. Usually people take people with them [to the assessment] you know, but I didn't want to, I wanted to be on me own. They thought I was all right to get there on me own and that's how they put it. They just didn't listen. I appealed, I tried to appeal, and in the end I just give up and went back on the dole.' (Andy, 46)

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 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). For instance, failure to attend a Jobcentre appointment can lead to an initial four-week sanction, in which the JSA benefit is suspended; any further error within the next year will lead to a 13-week sanction. There was a significant increase 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. The severity of the cuts, including the increase in rates of sanctions, has been linked to increased suicide rates in the UK (Barr et al., 2015b). In 2013, the suicide rate was at a 13-year high, with the region most affected being the North East (ONS, 2015). Andy talked about suicides in his local neighbourhood and attributed this to the rise in sanctions:

> '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)

Being caught up in the benefits system put many in a situation where they were powerless about the decisions being made about them. Alison spoke of the stress involved in this, although she remained committed to fighting unfair decisions. She spoke of the 'fear of the brown envelope', a theme identified in other research (Garthwaite, 2014):

> 'It's really, really got me so down and depressed. Regarding the benefit changes and having to fight for it. And then them realising you should have stayed on that one. Some people give in and they say "Ok, whatever." No. If that's right, then I'll fight for it. But it's dragged me down so much, because then you get into debt more, and you get more into this and have to find extra for that. It's hard, and when you're not well anyway. I dread them brown envelopes coming, I put them to one side and then I look away. It makes you feel sick inside, with everything. And with the pain all the time as well, that doesn't help. But what can you do?' (Alison, 50)

Narratives of powerlessness were present in discussions around a host of agencies, including housing, social services, GPs and the police. Negative encounters with formal agencies were repeated often. While there was at times a sense of helplessness in their narratives, people nevertheless responded to this lack of power with the resources that were available to them. Anger was a common response. Participants reported anger at the government and the benefits system and the impact that this had on their daily lives. They were also angry at the labelling and stigmatisation of them by the government and the media, and the impact this had on their self-esteem. Jimmy spoke about the

media portrayal of people who are not in work and the rise of the so-called 'poverty porn' on television:

> '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 two in the afternoon, 'cause that's what all people do on the dole. From 'Benefits Street' to refugees with six bedrooms.' (Jimmy, 47)

He went on to describe the impact of this and the feelings of shame that he had subsequently experienced:

> 'You know, I don't tell people that I don't work and stuff like that … you wouldn't dream of telling anybody that you're on the dole. You'd just make something up. Anything's better than saying you're on the dole. Believe me, when I'm in the garden with my kids, and my neighbour comes home from work, I can see that he hates me. When he sees that stuff on the telly and he sees me in the garden with my kids, it just reinforces what they're saying. That we're just lazy.' (Jimmy, 47)

The employment divide: work, health and mental health

The evidence base on employment and health suggests that being out of work negatively affects health and leads to worsening mental health (Bambra, 2016). However, insecure, poor-quality employment is also a risk factor for mental health (WHO/CGF, 2014): insecure employment can be equally as bad for health as unemployment (Kim and von dem 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, although as a result of her deteriorating health she was unsure how long she would be able to stay in work. Claire 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 had 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 Sainsbury's… I've worked at Tesco's 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 Tesco's, that was why I left there. I liked that job but it closed down and I lost my job.' (Claire, 49)

Claire had then trained to become a teaching assistant; however, the lack of permanent jobs meant that she had been 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.' (Claire, 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 (for example, Pemberton et al., 2014). 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 (for example, labourer). Lily had previously been a care worker for severely disabled people. She had loved her job; however; her physical health problems had affected her ability to work and she had to leave. Lily developed lumbar spondylosis, a degenerative disease of the spine. It 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 gentlemen 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 chronic 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' days and 'bad' days). When their physical health was bad, this often affected their mental health, and vice versa: the one would aggravate the other. Coping with pain appeared to have a particularly detrimental impact. Claire was living with significant pain on a daily basis as a result of fibromyalgia. She described the interaction with her mental health and how this affected her:

> '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 doctor's 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)

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. 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 remained in the police force for almost 30 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 five 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 [criminal investigation department]-type role in 1998 … And I've been pretty much doing that since then.' (James, 47)

Although these participants reported more secure employment histories, some also reported increasing job insecurity, increasing pressures and changing demands at work. For this group of people, austerity was particularly felt in relation to its impact on the working

environment, including the impact of reduced budgets and increased workloads. This gave people significant stress. Dennis discussed the impact of austerity on his work at HMRC:

> 'There's been a push in recent years, I can sum it up as more for less. So they wanted more money bringing in for less resource being put into it. So what you found was, since 2010, it's very political, there was more justification of the jobs, which is fair enough, but in return for investing a billion in the service they expect five billion back. So it was tough going. Very tough. A lot of people have found it very stressful. I've left friends there who are in a bad way, they're not happy. I've got one friend who I've been seeing in the summer, she's off work, with stress, she's going through what I went through a couple of years ago.' (Dennis, 57)

Psychosocial factors relating to work environments have all been shown to be damaging to mental health (for example, 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 affecting 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 talks about her changing role at work, initially the Department for Health and Social Security which then merged into Jobcentre 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 Jobcentre 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)

The interviews revealed a complex relationship between employment and its impact on mental health. Participants who were not in paid employment missed work and missed the benefits that work had provided. 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 affect mental health (Brunner and Marmot, 2006; Finne et al., 2014; Niedhammer et al., 2015). Notably, the work environment was one area in which austerity had an impact on people from the less deprived areas. For some this had led them to make decisions to remove themselves from the 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 had an impact on mental health in the less deprived areas, it more frequently had a physical health effect on people living in more deprived areas. 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. There was no evidence of a 'culture of worklessness' that has been represented in dominant narratives (Pantazis, 2016). This perspective places the blame for being out of work on 'faulty' behaviours and attitudes; 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. The lack of employment opportunities is borne out by the data. Office for National Statistics 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). Participants presented extensive employment histories and no culture of being 'workshy' or 'idle'.

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)

This final section considers the differences in the living environments of people in different areas of Stockton-on-Tees, and any associated impact on their mental health. 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 had

a strong 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 while others had moved in relatively recently. Most participants in these two groups were renting their current home. Participants from the deprived areas (and from the CAB) had lived in Stockton-on-Tees for most of their lives, often in the same ward. Their own personal identity was connected with the place where they had lived and grown up. 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; Warren, 2017) were at times reflected in the personal biographies of participants. Laura spoke of her connection to 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.' (Laura, 53)

Despite the strong ties that people had with the places they lived, there were key differences between those from the least deprived areas, the most deprived areas and the CAB. People in the more deprived areas were dealing with problems with housing, crime, and social problems such as drug and alcohol abuse, while those living in less deprived areas did not face these difficulties with their living environments. Curtis (2010) discusses the importance of the physical environment in terms of 'therapeutic landscapes' and 'landscapes of risk'. Therapeutic landscapes are the landscapes people live in that may benefit mental health. Conversely, landscapes of risk describe places that are damaging to mental health, 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 (Curtis, 2010).

This was a theme in which, alongside the differences between people living in the most and least deprived areas, there was also 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 they did not live in the *most* deprived areas of

the local authority). While some participants from the CAB discussed problems in their living environments, generally they perceived the streets they lived on as being relatively safe spaces. The concern about 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 (for example, 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 the 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, 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)

Along with several other participants in the most deprived group, Paul was also living in a home that had structural problems with damp and was in a poor condition. Paul was in the process of applying to move and 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)

Problems with living environments could at times have a significant impact on participants' mental health. However, the environmental and

social problems that people in the deprived areas were dealing with were largely absent in the narratives of those 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 was not 'what it once was', there was no sense of the physical environment having a damaging impact on participants' mental health. The 'therapeutic landscapes' (Gesler, 1992) literature discusses the potentially beneficial impact of certain natural environments on mental health, such as access to woodland or the coast. James had lived in Ingleby Barwick, one of the least deprived areas, for over 15 years with his wife and daughter. He talked about the area and reflected on how it was safe, affordable and met his family's needs, although he would have preferred to live somewhere more aesthetically 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. 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 all right.' (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 of the other participants, access to green spaces, woodland and more 'therapeutic landscapes' (Gesler, 1992) 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 people living in the most deprived areas.

Summary

This chapter has explored differences in the lives of people experiencing mental health problems in more and less deprived areas of Stockton-on-Tees. There were key differences in people's lives, and experiences, across a range of different areas. This included employment, finances and the physical environments that people were living in. 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, and to break away from situations that are harmful to their mental health. The people interviewed in the less deprived areas were still dealing with mental health problems and talked about how challenging this could be at times. Coping with mental distress was hard for everybody, regardless of their background. However there were additional pressures placed on those who were managing on low incomes and living in the more deprived areas of Stockton-on-Tees.

Poverty affects mental health. This includes the impact of living on a low income, the benefits system, unemployment/insecure employment, deprived housing and living in communities in which there is crime and other social issues. Poverty prevents people from being able to engage in normal everyday life and constrains the choices that people have. While people have agency to make their own decisions, and do so, those choices become increasingly limited when people are facing material hardship. Participants in the most deprived areas spoke of struggling financially and of finding it increasingly difficult to make ends meet. The stress that came about from a lack of money had a detrimental effect on their 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., 2009), unemployment and underemployment (Rogers and Pilgrim, 2003) and living in areas with high levels of deprivation (Curtis, 2010). Material deprivation compounds and exacerbates the difficulties people 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 effects.

This study has found that features of the austerity programme, in particular the welfare cuts, are disproportionately affecting those on the lowest incomes. While narratives about austerity were largely absent from the accounts of people living in less deprived parts of Stockton, they were pervasive in the lives 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. The relentlessness and rigidity of the benefits system aggravated the problems people had with their mental health, creating uncertainty and chronic stress. Since 2010 the series of cuts in welfare and in public spending has affected social inequality in the local authority, and is ultimately having an impact on the mental health of the people who are bearing the brunt of those spending cuts. 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.

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 UK 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. This has included a move towards shrinking the role of the state and a further restructuring of the state along market lines. 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 have permeated 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). Social safety nets are being removed to such an extent that people are increasingly left without enough income to be able to meet even basic necessities. This is not acceptable. Poverty is a social – and a political – problem.

A continuation of these regressive measures is likely to lead to growing inequalities, and lives that are even further separated by social division. Planned changes in social security include further reforms to Housing Benefit and the imminent rollout of Universal Credit, a benefit that is best understood as a repackaging of six means-tested existing working-age benefits (Beatty and Fothergill, 2016). The government is currently moving forward with the implementation of Universal Credit, despite widespread and significant concerns about its design and implementation. Failures throughout the implementation period mean that the rollout is five years behind schedule. Claimants must wait for a minimum of six weeks for a first payment (although typically residents in some areas are waiting for 12–13 weeks), effectively leaving them without any income at all in this period (Butler, 2017). As a result, rent arrears have skyrocketed in the areas in which it has been tested and people have been forced into debt and significant financial hardship. Concerns have been so vocal and widespread that the chief executive of Citizens Advice argued that this is 'a disaster waiting to happen' (Cowburn, 2017). If the rollout continues as planned, this is likely to have a severe impact.

Issues relating to poverty and deprivation are central determinants of poor mental health. 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, which has a significant impact on 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 wellbeing. 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.

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"The combination of an interdisciplinary lens and quantitative and qualitative data creates a much-needed but shocking depiction of the impacts of austerity on social and health inequalities at a local level. The book illuminates how austerity as a political discourse is being used to justify deeply pernicious and deliberate shredding of the public welfare fabric."

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How has austerity affected health and wellbeing in the UK? Health in Hard Times explores its repercussions for social inequalities in health.

The result of five years of research, the book draws on a case study of Stockton-on-Tees in the North East of England, home to some of the starkest health divides. By placing individual and local experiences in the context of national budget cuts and welfare reforms, it provides a holistic perspective on countrywide inequalities.

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Clare Bambra is Professor of Public Health in the Institute of Health and Society at Newcastle University.

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