

Mental Illness and Stigma from a Socioeconomic  
Perspective

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## Abstract

**Background:** The stigma associated with mental illness has a detrimental impact on a range of outcomes for those who experience it. Further to this, repeated attempts to address the health and social inequalities associated with mental illness have had limited success and these remain entrenched. Such patterns of marginalisation may be exacerbated by difficult economic circumstances. The thesis aims to explore the relationship between socioeconomic factors and the stigma associated with mental illness, with particular reference to the post-2007 recession context in the UK and Europe.

**Methods:** A mixed methods approach was used incorporating three studies. Interviews with welfare claimants experiencing mental illness and an administrative data analysis investigated the impact of recent UK welfare reforms in relation to experiences of stigma and disadvantage. A cross-national European analysis explored the relationship between socioeconomic factors and attitudes towards people with mental illness.

**Findings:** Interviewees (n=18) described feeling stigmatised, disempowered and financially disadvantaged by their experiences of the UK welfare system. Analysis of administrative data on claimants revealed that people with mental illnesses are around 2.40 (95% CI: 2.36, 2.44) times more likely to be considered ineligible for extra-cost disability payments than people with other health conditions following recent reforms. European data suggests that individual financial difficulties, greater income inequality and a higher disability poverty and social exclusion gap are key socioeconomic factors that associated with less tolerant attitudes towards people with mental illnesses.

**Conclusion:** Taken together, the findings suggest that micro and macro level economic factors are implicated in stigma and can contribute to climates of tolerance or disadvantage for people with mental illnesses. Extending the parity of esteem agenda to other institutions such the welfare system may assist with addressing some of these inequalities, alongside greater recognition of the role of socioeconomic factors and power in perpetuating stigma and disadvantage.

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## **Preface**

Now more than ever, mental health has become a central focus of governments across the United Kingdom and Europe. Recognition of the detrimental impact of mental illness on individual lives coupled with the costs to economies of over a quarter of people experiencing a mental illness during their lifetime, has provided an impetus for finding new ways of addressing this global health concern. Increasingly over time, attention has turned to the role of stigma in limiting the opportunities of people with mental illnesses. Although research emerged from the 1950s onwards when the deinstitutionalisation project began in earnest, there has been a renewed focus on stigma over the past twenty years in mental health research and campaigns.

The global recession of 2007 led to an increase in the type of socioeconomic factors that have well-documented links with mental illness, such as deprivation, unemployment and financial difficulties. As such, findings that mental illnesses have also increased at the population level during this time are to an extent predictable. This also means that mental illness does not affect any one in four people at random but is concentrated in those experiencing socioeconomic deprivation. Evidence highlights that macro socioeconomic factors are also associated with mental illness. Income inequality and access to the financial resources that prevent poverty, such as social security, are both examples of factors that may be linked to mental health.

Poverty is not only about income but about the wider socioeconomic conditions that are associated with deprivation. These may include housing, transport and a reduced range of employment opportunities. In this way, the wider experience of poverty is associated with marginalisation and social exclusion. Socioeconomic deprivation is also associated with stigma and increasingly so in the context of narratives associated with public spending reductions and explanations of poverty that focus on individual choice and behaviour.

It is this post-recession context in which the thesis is situated. It takes a socioeconomic perspective on the stigma surrounding mental illness and seeks to understand whether and how socioeconomic factors may be associated with this particular form of stigma, at both the micro and the macro level. In doing so, the thesis proposes that these forms of stigma may intersect. It argues that the socioeconomic context is key to understanding why patterns of stigma appear to

remain entrenched for people experiencing mental illness, despite efforts to improve social inclusion.

### **Thesis Aim**

The aim of the thesis is to understand whether there are links between socioeconomic factors and the stigma associated with mental illness in the post-2007 recession context across the UK and Europe.

### **Thesis Structure**

The thesis begins with an overview of the literature as it relates to socioeconomic status, mental illness and stigma. The first chapter discusses the existing evidence on stigma, detailing different explanations and setting out how stigma can arise at both the interpersonal and structural level. It defines the theoretical framework for the research and considers how different forms of stigma may interact and intersect. Chapter two explores the relationship between mental illness and socioeconomic status, how research in this area has evolved over time and the role of health inequalities evidence in the development of current understandings. It explores the deinstitutionalisation process and theorises that these historical patterns and the subsequent move to community care have defined the relationship between mental illness and socioeconomic deprivation. After outlining evidence in relation to individual socioeconomic factors, the chapter then moves on to set out the research relating to the broader economic and political determinants of mental ill health. Chapter three focuses on the specific socioeconomic context of the thesis. It considers the impact of recession and reductions in public spending on both mental illness and stigma.

The methodology section of the thesis begins by outlining the critical realist epistemological and ontological foundations of the thesis. It explains how this framework relates to the theoretical model and how it informs the mixed-methods design of the research. Chapters four to six detail the methods for each of the three component parts of the research: an interview study, an analysis of administrative data and a cross-national European data analysis.

The results section of the thesis contains three chapters, outlining the findings of each of the three studies. This structure is designed to ensure the findings are

presented with clarity, given the varied approaches to data collection and analysis employed in the thesis. Each of the chapters therefore contains a discussion relating to the findings of each specific study. Triangulation of the findings, in keeping with a mixed-methods approach, is undertaken in the overall discussion at the end of the thesis.

The aim of the overall discussion chapter is to highlight the key findings from the research and to consider the overarching theoretical and methodological issues in the thesis as a whole. It discusses whether the research has achieved the thesis aims and whether it has successfully measured stigma from a socioeconomic perspective. The role of the methodological framework is explored, and this is employed to triangulate the findings and to situate these in the critical realist context. This chapter considers the limitations to the project as a whole before outlining the strengths and contributions of the findings to the broader research and policy context. A series of recommendations based on the research and a final conclusion ends the thesis.

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## **Author declaration**

I declare that this thesis is a presentation of original work and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as references.

Part of this thesis has been submitted for publication:

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## **Section A: The Literature**

## **Introduction**

There are three key aims to this literature review. Firstly, I will set out theoretical debates on the concept of stigma and identify the framework in which the research will be grounded. Secondly, I will discuss the social, historical and political context in which the research is situated, fundamental to understanding the ways in which stigma has emerged and been maintained over time. Finally, I will use this information to hypothesise how broader socioeconomic conditions and in particular, the post-2007 recession context, are linked with the stigma surrounding mental illness.

Chapter one will explore stigma as a theoretical construct. The development of a cohesive definition of what stigma is and how the stigmatisation process works remains ongoing and research in this field is wide ranging. It incorporates conceptualisations of stigma, definitions of different types of stigma and the impact of stigma on individual outcomes. I will aim, by synthesising this evidence, to emphasise the key aspects of stigma with relevance to the thesis and in doing so, arrive at a practical definition and framework for use in the research. I will use existing evidence to move beyond traditional, individualised conceptualisations, to think about how stigma may also be inherent in the procedures and practices of institutions.

Chapter two aims to provide further context to the research. By documenting the historical, political and social background to the treatment and care of people with mental illness, it explores the continued links between mental illness and socioeconomic disadvantage, proposing that these have emerged from the specific environment of deinstitutionalisation and the subsequent but often less emphasised community context. It discusses how wider socioeconomic conditions are linked with mental illness and how the ways in which economic resources are distributed may contribute to continued links with disadvantage.

Chapter three explores the intersection between stigma, socioeconomic disadvantage and mental illness and situates this in the post-2007 recession context. It explores the role, not only of individualised forms of stigma occurring through everyday interactions but also of structural forms of stigma, in creating an environment that perpetuates and reimagines existing forms of stigma surrounding mental illness



through the lens of narratives associated with welfare claimants and worklessness. It examines how characteristics of mental illness become entrenched in negative attitudes towards welfare claimants and in doing so, considers the intersectional nature of these different forms of stigma. After synthesising the evidence, I will then outline the overall research aims.

# **Chapter 1: Stigma theory and concepts**

## **1.1. Introduction**

As this chapter will demonstrate, the stigma associated with mental illness exerts a range of adverse effects on those who experience it, impacting on individual self-esteem, interpersonal relationships and life chances. The aim of this chapter is to outline the different forms of stigma with relevance to the thesis and to draw together conceptualisations of stigma to provide a theoretical framework to underpin the research. The chapter begins with definitions of the main types of stigma, a categorisation that is relatively cohesive in the literature. This section has been broadly separated into interpersonal and structural forms of stigma and I have aimed to discuss the theoretical basis on which these are founded and to distil key elements of the literature. The chapter then discusses the stigmatisation process and the ways in which this has been conceptualised. Finally, a theoretical framework for the research is proposed.

## **1.2. Interpersonal Stigma**

### **Individual experiences of stigma**

Negative stereotypes associated with mental illness include violence, incompetence and unpredictability and more often than not, greater endorsement of such stereotypes has been associated with increased anger, fear and social distance towards people with mental illnesses (Makowski et al., 2016; Sadler, Kaye and Vaughn, 2015; Angermeyer, Beck and Matschinger, 2003). Stigma has real and detrimental consequences for those who experience it. In a survey of 194 individuals diagnosed with depression, psychosis or bi-polar affective disorder, Farrelly et al. (2015) found that experiences of stigma and discrimination were associated with increased hopelessness, suicidal thoughts and self-harm attempts. Further to this, simply the anticipation of negative treatment by others led respondents to isolate themselves, meaning that harmful consequences can arise regardless of whether the person experiences actual prejudice from others. This demonstrates how far reaching the effects of negative stereotyping can be and is one of the ways in which stigma can become linked to social exclusion.

Self-stigma refers to the application of stereotypes about mental illness by the individual experiencing mental illness to themselves. For self-stigma to arise, a person experiencing mental illness must be aware of the negative stereotypes surrounding mental illness, to agree with these stereotypes and then view themselves negatively as a result (Corrigan et al., 2016). Awareness may arise directly during interpersonal interactions in which such stereotypes are expressed by others or indirectly through socialisation, for example, media reporting, so that if a person later develops a mental illness, certain attributes are then applied to the self (Thornicroft et al., 2016). Once internalised, negative stereotypes can hold significant implications for self-esteem (Corrigan, Rafacz and Rüsche, 2011).

Arguably, it would be difficult for most people in the United Kingdom (UK) not to be aware of negative stereotypes surrounding mental illness. A study on UK media reporting of mental illness, analysing articles published between 1998 and 2008,

found that whilst the number of stories linking mental illness to violence has reduced over time, this remained the largest topic area of all articles on mental illness (Murphy, Fatoye and Wibberley, 2013). Research also demonstrates that coverage of violence and mental illness has clear links with public attitudes towards mental illness. McGinty, Webster and Barry (2013) for example, found that media reports on mass killings in the USA increased public fear around people with mental illnesses immediately afterwards.

The key element in the production of self-stigma, however, is not the stereotypes alone but the internalisation and application of such stereotypes to the self. It is therefore also feasible that a person with mental illness may be aware of such negative stereotypes without believing they are personally applicable. The concept of 'felt stigma' addresses this disparity by acknowledging that not all individuals with a stigmatised attribute will necessarily internalise stereotypes even when they are aware of their existence (Baumberg, 2016). Felt stigma perhaps reflects increased empowerment on the part of those experiencing mental illness to challenge the attitudes of others in the context of an increase in campaigns to raise awareness about mental illness over recent years (see for example, Time to Change, See Me, Heads Together). By raising awareness about mental illness, those who experience it may be more able to reject these stereotypes as personally applicable and feel supported in doing so. Thoits (2011) highlights that resistance to stereotypes is often neglected in traditional labelling theory accounts that emphasise the passivity of the stigmatised. In actuality, people with mental illnesses can and do challenge negative stereotypes and not everyone with a mental illness may feel stigmatised.

### **Public Stigma**

Identifying and improving public attitudes has been a key focus of research relating to the stigma surrounding mental illness. This is perhaps because understanding widespread attitudes and targeting interventions accordingly has the potential for large scale impact. Changing public attitudes may improve social integration, reduce discrimination and address the detrimental impact of self-stigma (Campellone, 2014).

Building on existing models of stigma, it has since been suggested that the reliance on stereotypes to form attitudes about people with mental illness is indicative of a lack of knowledge about this type of health condition (Thorncroft, 2006). In fact, mental health literacy has been linked not only with attitudes towards people with mental illnesses but with levels of treatment seeking (Sheehan, Nieweglowski and Corrigan, 2016) so that the benefits of higher levels of mental health literacy are twofold, improving tolerance and increasing the likelihood of people accessing health services in the event that illness does develop. As may be expected, there are differences in levels of public knowledge by type of mental illness. Borderline personality disorder, for example, has the same prevalence in the adult population as schizophrenia but knowledge of symptoms and awareness of recommended treatments is much lower (Furnham, Lee and Kolzeev, 2015). The nature of the stereotype may also differ depending on the specific mental health condition (Angermeyer and Matschinger, 2003).

Taken together, this evidence suggests that knowledge about mental illnesses could hold implications for both uptake of services and public attitudes. Although multiple campaigns over the past twenty years have attempted to reduce stigma by educating the public about mental illness, there is debate as to whether this has brought about any actual improvement to attitudes and public stigma remains problematic (Dinos, 2014; Evans-Lacko et al., 2014; Angermeyer et al., 2014). In particular, more evidence is needed in the European context to evaluate the effectiveness of anti-stigma programmes and so demonstrate value (Quinn et al., 2014).

There is evidence to suggest that the type of knowledge used to educate people about mental illness has important implications and it is possible that the rise in biogenetic explanations of illness, for example, genes, chemical imbalances, may have inadvertently contributed to continued stigma. Attribution theory suggests that anger and blame are higher when a person is perceived to be the cause of their own difficulties and so biogenetic explanations of mental illness were initially thought to reduce stigma because of the underlying assumption of reduced personal responsibility (Rüsch et al., 2010). There is evidence, however, that whilst biogenetic

explanations reduce blame, they are associated with fear and increased social distance, perhaps because of ‘genetic essentialism’, where the illness is viewed as an unchangeable characteristic (Rüsch et al., 2010; Angermeyer et al., 2014b). In fact, a meta-analysis of twenty-eight studies focusing on the relationship between biogenetic explanations and public attitudes towards mental illness found an association with pessimism about recovery and endorsements of stereotypes of dangerousness (Kvaale, Haslam and Gottdiener, 2013). These views are widely held. Between 45-51% of people in developed nations agree that mental illness is similar to physical illness and only 7% agree that people will be able to recover from their illness (Seeman et al., 2016). This holds implications not only for attitudes but for the consequences of internalising such attitudes which could feasibly lead to increased hopelessness.

The popularity of biogenetic explanations is a relatively new phenomenon and represents a shift towards more medicalised and individualised models of illness. Clarke and Gawley (2009) explored changes to how depression has been conceptualised in popular media between 1980 and 2005, finding a shift away from explanations focusing on difficult life events and socioeconomic circumstances and towards depression as a medical phenomenon requiring pharmaceutical treatment. They argue that a focus on individualised and medicalised treatments moves attention away from the social and structural causes of mental illness. In turn this prevents solutions that focus on addressing the social and economic drivers of depression, such as poverty (Clarke and Gawley, 2009). Similarly, Voas (2014) suggests that a shift away from individualised understandings of attitudes is also needed, a ‘sociology of attitudes’, to understand the wider sociocultural factors contributing to individual prejudices.

Concentrating attention on individual, interpersonal explanations of stigma could therefore be ignoring the underlying societal factors contributing to both mental illness and attitudes towards those who experience it. Whilst biogenetic explanations of illness prevail, they may inadvertently contribute to continuing stigma.

### **1.3. Structural Stigma**

Structural stigma refers to institutional policies and practices that carry an inherent bias against certain individuals or groups. The concept has origins in theories of institutional racism, through an understanding that racial discrimination occurs not only during interpersonal interactions but may also be inherent in institutions (Corrigan, Markowitz and Watson, 2004). It is defined as:

“The legitimization and perpetuation of a stigmatized status by society’s institutions and ideological systems” (Bos et al., 2013).

Much of the focus of research on the stigma associated with mental illness has to date been on interpersonal forms of stigma and this emphasis has shifted attention away from the wider sociocultural and structural context of stigma (Thorncroft, 2006). In a recent review of stigma research to date, Bos et al. (2013) explored the evidence base for each of four main domains: public stigma, self-stigma, stigma by association (family members and carers) and structural stigma. They find that structural stigma is an area that suffers from a significant lack of research, despite a growing recognition of the influence of societal level factors on all other types of stigma. This means that research and awareness of the structural drivers implicated in perpetuating the stigma associated with mental illness has so far been limited.

Structural stigma can be intentional, in the case of policies intended to discriminate against a certain group on an arbitrary basis (Corrigan et al., 2004), for example, direct underfunding of mental health services. It may also be unintentional, where policies or institutional actions have unintended consequences that disproportionately impact on particular individuals, for example, through acting on characteristics that have become associated with mental illness via other societal processes (Livingston, 2013), such as the well-established links between mental illness and socioeconomic disadvantage (Marmot, 2010). It is because of these links that people with mental illnesses may be disproportionately affected by any changes to state institutions such as the welfare system. Nelson, Kloos and Ornelas (2014) suggest that although direct mental health policies may have become more progressive over time, income and housing policies have become more regressive, meaning that disadvantage is perpetuated indirectly.



To illustrate, an example of indirect structural stigma is provided by Hunter (2007) through the interpretation of the legal term ‘vulnerability’ in the Housing Act (1996) by Local Authorities in England. The term ‘vulnerable’ in this context is used to identify all those who are entitled to be prioritised for Local Authority housing and is defined as being vulnerable as compared to an ‘ordinary homeless person’. Hunter (2007) suggests that by arguing that an ‘ordinary homeless person’ might be expected to experience mental health difficulties in relation to their situation, Local Authorities have reduced the number of people entitled to priority housing, since claimants with mental health issues are no longer classified as any more vulnerable than an ordinary homeless person. Hunter (2007) argues this is a misuse of the term vulnerability designed to reduce the number of people towards whom Local Authorities are obligated to provide housing, in which people with mental health issues would ordinarily be disproportionately featured.

The social, cultural and political context of stigma is therefore important because it provides the conditions in which stigma may or may not exist and for disadvantage and marginalisation to arise or be prevented. Greater awareness of these structural factors is needed to increase understanding of how stigma is produced and maintained and how this links in with interpersonal experiences.

#### **1.4. Conceptualising Stigma**

Theoretical understandings of stigma may explain why much of the existing focus has been at the interpersonal level whilst the contextual factors that facilitate stigma have been neglected. This section will outline theoretical perspectives relevant to the thesis and consider how these link in with different types of stigma.

Although there are now multiple theoretical approaches to the study of stigma, it is the framework provided by Goffman (1963) that remains dominant (Tyler and Slater, 2018). Goffman’s application of labelling theory to mental illness states that individuals become ‘marked’ by the stigmatising attribute of having undergone admission to a psychiatric hospital or by receiving a psychiatric diagnosis. Once labelled with a mental illness, the person is perceived as ‘discredited’ by others in

their community. This represents a ‘moral stigma’ in which the stigmatised attribute is perceived as representing a blemish on the character of the person (Thoits, 2011). The outcome is a spectrum of marginalisation ranging from difficult social interactions through to exclusion from wider participation in community life. As such, for Goffman, stigma is a devaluing experience. Where the ‘mark’, in this case, mental illness, is not immediately visible, the person has the option to disclose their stigmatising attribute to others or to conceal it (‘pass’) during interactions, however, whilst a person holds an attribute that is ‘discreditable’, there is always the potential it will be uncovered, causing tension and impacting on self-esteem (Corrigan et al., 2016).

Key to the conceptualisation of the stigmatisation process proposed by Goffman is the recognition that stigmatising attributes are not a characteristic of the individual but are situated within interpersonal interactions and therefore socially constructed. It is centred around social norms and those who carry attributes that are perceived as a deviation (Bos et al., 2013). Despite being a primarily sociological interpretation of stigma, however, the social interactionist tradition informing Goffman’s definition means that much of the detail of the stigmatisation process is focused at the micro level. This individualised understanding has made a significant contribution to defining the role of self-stigma and public stigma and has led to the development of the social cognitive model of stigmatisation, which seeks to provide an in-depth exploration of the component parts of stigma by adopting and expanding on Goffman’s original definition (Thornicroft et al., 2016). In line with psychological approaches, this model separates the stigmatisation process into three key domains: cognitive, emotional and behavioural.

In the cognitive domain, the labelling of a person with a mental illness creates an association with existing and often negative stereotypes. Once processed, this information produces an emotional reaction based on the stereotype and may generate associated behavioural actions. Although in general psychological terms, stereotyping can be a useful cognitive ‘shortcut’ for processing the vast amounts of information we come into contact with on a daily basis, it becomes problematic when based on faulty information (Link and Phelan, 2001) and can have serious consequences. Thornicroft (2006) has revisited the domains of the social cognitive

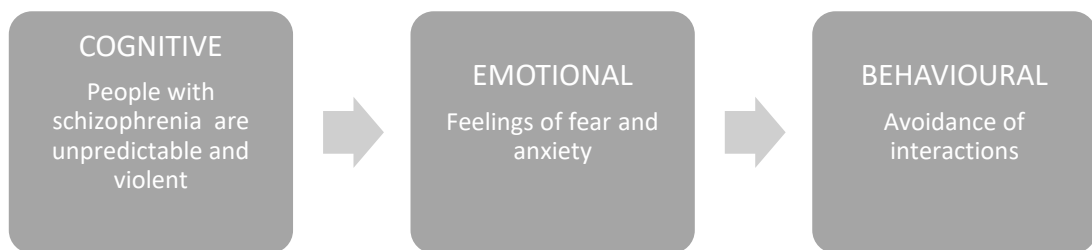
model to explain how each produces a problematic element of stigma. Figure 1 provides an example of how each of the components link together.

**Cognitive: Problems of knowledge:** Negative stereotypes relating to mental illness arise from faulty information associated with particular diagnostic labels. This part of the process therefore originates in a lack of accurate public knowledge about different mental disorders.

**Emotional: Problems of attitudes:** In this domain, stereotypes lead to overly negative appraisals of the person with a mental illness, creating prejudice and associated emotional reactions such as fear or anxiety.

**Behavioural: Problems of discrimination:** The final consequence of stereotyping and prejudice is a behavioural action which results in a form of exclusion or discrimination for the person with a mental illness.

Figure 1. The social cognitive model of stigma.



By separating the process into three sequential parts, the social cognitive model allows for a more detailed exploration of how stigma arises and is enacted, being particularly useful in explaining how stigma can arise without any previous negative interactions with a person diagnosed with a mental illness, since thoughts and actions can be influenced by stereotypes perpetuated in wider society, as described earlier in the chapter. Evidence suggests that if people are unfamiliar with a certain social group, they are more likely to rely on sources of information that provide ‘social proof’ of how to think rather than on their own opinions when forming attitudes (Sechrist and Stangor, 2007), meaning that enhancing public knowledge is key to preventing subsequent negative emotional and behavioural consequences.

The perspective provided by Goffman and subsequently expanded by Thornicroft has been highly influential in explaining the role of public and self-stigma but has arguably produced a research paradigm focused on individuals rather than considering the wider structural factors that may produce and perpetuate stigma (Corrigan et al., 2004). This means that the role of power, often a key factor in the dominance of one social group over another, is overlooked in interactionist conceptualisations of stigma. Whilst the thesis will therefore incorporate interactionist perspectives and acknowledges their importance in the field, an alternative approach taking into account both the interpersonal and the structural is needed here because of the focus on exploring links between individual attitudes and experiences of stigma, and the broader socioeconomic context.

### **Reimagining stigma in the context of power**

Link and Phelan (2001) incorporate both interpersonal and structural perspectives into their conceptualisation of stigma. Here, labels are linked to ‘undesirable characteristics’ and act to produce negative stereotypes which in turn results in the separation of labelled individuals into a distinct category, creating ‘us’ and ‘them’. Once separated in this way, the person with a mental illness may experience status loss that can subsequently lead to discrimination. This model bears many similarities to the social cognitive model but crucially, Link and Phelan argue that the entire process takes place in the context of power.

Power enables certain cultural beliefs about which characteristics are designated as undesirable to become dominant (negative stereotyping) and produces the conditions for discrimination. This is summed up in the following quote from Link and Phelan’s description of the process:

‘Stigmatization is entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the separation of labelled persons into distinct categories, and the full execution of disapproval, rejection, exclusion and discrimination’ (p.367).

Although it may be that power is not immediately relevant to all interpersonal interactions involving stigma, this conceptualisation has value because it demonstrates the importance of moving beyond individualised approaches by suggesting that stigma requires particular societal conditions and systemic practices to thrive. Disempowerment is as much a part of feeling stigmatised as the impacts on self-esteem and interpersonal relationships discussed earlier in this chapter.

Phelan et al. (2014) extend the discussion of the role of power further in their application of Status Characteristics Theory (SCT) to the stigmatisation process. SCT suggests that macro level forms of social stratification are reproduced at the micro level, manifested as how much value the individual is assigned by others during interpersonal interactions. This value is based on characteristics informed by broader inequalities, for example, socioeconomic status or ethnicity. Phelan et al. (2014) propose that there is a hierarchical element absent from Goffman's discussion of the problematic interactions between stigmatised and non-stigmatised individuals, known as 'mixed contacts' (Goffman, 1963). Far from being equal interactions in which only the master status of mental illness carries importance, they argue that secondary characteristics such as socioeconomic status will also influence the degree to which stigmatisation and devaluing of the person occurs. Phelan et al. (2014) provide a useful adjunct to Link and Phelan's (2001) initial conceptualisation because SCT introduces the scope to explore how different stigmatised statuses may interact in certain contexts, for example, in the intersectionality between being mentally ill and socioeconomically deprived. This means that experiences of stigma, particularly in relation to disempowerment, may differ according to both diagnosis (as discussed earlier) and individual characteristics such as socioeconomic status.

Building on their existing work, Link and Phelan (2013) have since defined the ways in which power is relevant to the stigmatisation process. They suggest that societal level cultural beliefs about mental illness create social structures that either overtly or covertly aim to keep people with mental illnesses 'down', 'in' (where deviations are subject to social disapproval) or 'away'. The drivers of stigma remain hidden because they manifest primarily as self-stigma, in which the person adopts broader stereotypes and applies these to the self (Link and Phelan, 2013). When the person with mental illness displays behaviours associated with self-stigma, such as

withdrawal from social interactions or attempting to ‘pass’ and hide their illness to avoid being discredited (Goffman, 1963), the problem is seen as individual and not as having structural origins.

### **Linking forms of stigma together**

The difficulty in relation to the concept of societal level ‘cultural beliefs’ as described here by Link and Phelan (2013) is in distinguishing where public stigma, which is usually classified in stigma models as interpersonal, ends and structural forms of stigma begin. There is also disparity in how the two terms are operationalised for research purposes, whilst some definitions of structural stigma focus wholly on institutional practices and policies, others incorporate the ‘cultural norms’ of a particular country which may include measures of public attitudes about mental illness (Hatzenbuehler and Link, 2014). Although potentially a very comprehensive measure of the way country level factors could impact on people with mental illness, incorporating such measures of cultural norms is problematic given that theoretical models suggest that structural factors and public attitudes are distinct concepts in relation to the stigma associated with mental illness (Link and Phelan, 2001; Bos et al., 2013).

Further difficulties arise in ascertaining the direction of causality between institutional policies or practices and public attitudes (Evans-Lacko et al., 2012). Narratives associated with certain policies may influence public attitudes, but it is equally feasible that public opinion could influence policy direction and the presence or absence of a particular policy does not provide information on how effectively or extensively it has been implemented. The measurement of structural stigma more broadly is also potentially problematic given that this is a relatively abstract concept, systems are complex, and it may be difficult to provide conclusive evidence of inherent biases at the societal level.

Nevertheless, theories of structural stigma provide a useful adjunct to existing understandings of the stigmatisation process whilst also demonstrating a clear need to explore the contextual factors contributing to the production and maintenance of stigma. Understanding how different forms of stigma link together is important for

determining how societal level factors and individual experiences of stigma may be associated. Key to developing this understanding is the identification of effective ways to measure societal level drivers of stigma.

Commonly, analysis of structural factors on individual outcomes uses a comparative approach to explore differences between countries or in the case of North America, states, therefore enabling more detailed study of the role of context. Evans-Lacko et al. (2012) used two large European datasets to explore the relationship between public attitudes and self-stigma across fourteen countries. They found that less stigmatising attitudes, higher rates of help seeking, treatment utilisation and better access to mental health information at the country level were associated with lower self-stigma and perceived discrimination at the individual level, though there are clearly questions about the direction of causality here. Policies, laws and cultural norms have been associated with health inequalities amongst minority groups across a range of indicators such as substance misuse, myocardial infarction and mortality (Hatzenbuehler and Link, 2014) and similarly, Pachankis et al. (2015) found that country level stigma, measured by laws, policies and public attitudes towards sexual minorities was associated with higher unmet health needs and concealment of sexual orientation amongst men who have sex with men.

Despite the measurement difficulties described here, taken together these findings suggest that there may be evidence of links between macro level factors such as particular policies and practices, and individual experiences of stigma.

## **1.5. Research Framework**

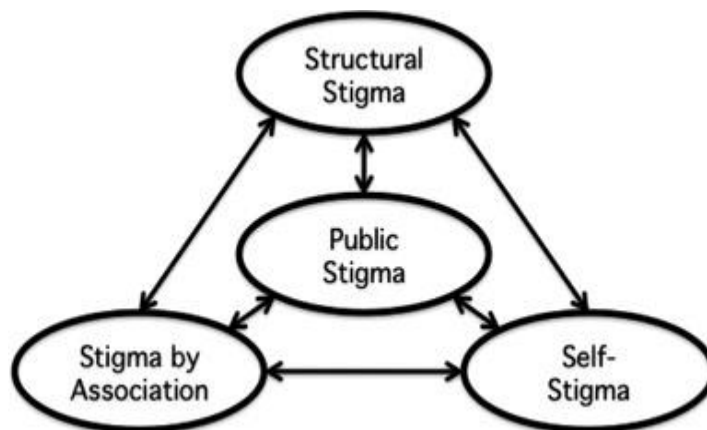
The focus of the research is on understanding whether there are links between socioeconomic factors and the stigma associated with mental illness in the post-2007 recession context. The choice of this specific setting for the research is discussed further in the following two literature review chapters.

Exploring the role of socioeconomic factors requires consideration of both individual and societal level conditions; therefore both the interpersonal and the structural may be important. This will be reflected in the adoption of the theoretical model of the

stigmatisation process proposed by Link and Phelan (2001) which seeks to understand the social, economic and political drivers of stigma. In keeping with status characteristics theory, studying stigma in relation to socioeconomic factors also means understanding that it would be problematic to separate the stigma of mental illness from the stigma of other characteristics such as socioeconomic status, unemployment and being a user of the welfare system (Poole, Higgs and Robinson, 2013).

Bos et al. (2013) have developed a conceptual model (Figure 2) demonstrating how different forms of stigma are associated by proposing a bi-directional, hierarchical relationship between structural and interpersonal stigma and this framework will act as a theoretical basis for exploring how the research findings may fit together. Traditionally, stigma research has focused on exploring one component, for example, public stigma, but this approach is limited because it does not provide an in-depth understanding of context. In planning this research, I have therefore chosen to take the approach of focusing on both experiences of stigma and the drivers of it and in doing so to give consideration as to how these might be linked.

Figure 2. Conceptual framework



In this context I propose that socioeconomic factors are associated with both public attitudes towards people with mental illness and with experiences of stigma, at both the micro and macro level. I suggest that the post-2007 recession socioeconomic context has exacerbated these associations and that there are historical foundations to



this relationship. To the best of my knowledge, this will be the first piece of research that attempts to link different forms of stigma in relation to both mental illness and socioeconomic factors. Stigma by association or ‘courtesy stigma’ refers to the stigma experienced by those who are associated with a stigmatised person, for example, carers of people with mental illness. Although clearly the experiences of carers and relatives are important, I have chosen not to incorporate this form of stigma into my research to keep the project manageable in terms of scope.

## **1.6. Conclusion**

This chapter has set out the different forms of stigma as found in the literature, making a distinction between interpersonal forms of stigma and structural drivers of disadvantage. Theoretical frameworks have been discussed, which although relatively cohesive over the past seventy years, have been updated and modified to incorporate a cognitive-behavioural conceptualisation of the stigmatisation process. Individualised explanations of mental illness and the focus on interpersonal stigma have, however, shifted attention away from the structural origins of both mental illness and stigma.

Updated conceptual frameworks offer recognition of the role of power and structural factors, suggesting that there is a need to look beyond interpersonal interactions and towards the underlying determinants of the experiences of individuals. Whilst the relevance of the structural in maintaining forms of prejudice is not a new concept, it has been neglected in the field of stigma and mental illness, arguably because of a focus on the interpersonal that is grounded in the dominant interactionist paradigm associated with this type of research.

Since the proposed research will consider the interaction between individual experiences and structural drivers, a move away from traditional stigma theory and towards a conceptual model that acknowledges these factors is required. The next two chapters will consider the context for the research, both from a historical perspective and in relation to post-2007 socioeconomic conditions.

# **Chapter 2: Deinstitutionalisation, Disadvantage and Social Inclusion**

## 2.1. Introduction

Throughout history, people with mental illness have been treated as a marginalised population – as lacking spiritual or moral strength and latterly as part of the ‘undeserving poor’ (Abdul-Hamid and Bhui, 2014). Today, mental illness affects one in four individuals globally and together with substance misuse issues accounts for 22.9% of years lived with disability worldwide, a rate that has risen by 41% between 1990 and 2010 (Whiteford et al., 2015). Yet it is ‘not just any one in four’ who are affected (Rogers, 2003) and strong links exist between mental illness and socioeconomic deprivation at both the individual and area level (Marmot, 2010; Rogers and Pilgrim, 2010). People with mental illnesses continue to experience barriers to education and employment (Schindler and Kientz, 2013) and form the largest group of welfare claimants in the UK (Moncrieff and Viola, 2016).

Understanding the social, cultural and political context surrounding these inequalities is necessary for situating the research in the current socioeconomic climate. This chapter will consider change over time, the emergence of mental health inequalities research and theoretical explanations of disadvantage. I will argue that the origins of continuing disadvantage have historical roots in deinstitutionalisation and the transition of mental health care and treatment to the community. Alongside individual financial circumstances, the chapter will also consider the evidence on how broader socioeconomic factors impact on mental illness.

## **2.2. Mental illness and socioeconomic status**

The role of socioeconomic status in producing identifiable patterns of illness has long been acknowledged in epidemiological research and more recently has gained traction as an independent determinant of health. Initially, socioeconomic status was viewed as a potential confounder or alternatively research focused on comparisons above and below a dichotomous ‘poverty line’ (Adler and Ostrove, 1999) but although this approach did offer some indication of the relationship between socioeconomic status and health, it was revealed by later evidence to be an oversimplification. The introduction of research such as the Whitehall studies, conducted with civil servants in England, clarified that the health of people at all income levels is affected by their social position, not just those below the absolute poverty line (Marmot and Smith, 1997). In fact, this evidence suggested that there were stepped changes in health at each level of socioeconomic status, with health improving the higher the social position. Known as the ‘social gradient’, these findings have since been replicated internationally (World Health Organisation, 2014) and across a multitude of different health conditions including both physical and mental illnesses (Prins et al., 2015; Ban et al., 2012). As such, health inequalities research has often been at the forefront of exploring the social patterning of mental illness.

### **The Social Gradient of Mental Illness**

Although the social gradient affects people at all income levels, it is those in the most deprived economic circumstances who are more likely to experience the worst mental health and since this represents a significant health inequality, it is these findings in particular that have received sustained attention. The Marmot Review (2010) or ‘Fair Society, Healthy Lives’ sets out extensive evidence relating to health inequalities in the UK, proposing solutions focused on reducing the widening health gap between rich and poor. The review highlights that the social gradient of health is particularly strong for mental illness and these differences exist not only for individuals, but also at the neighbourhood level in which more deprived areas are associated with worse mental health outcomes. The report argues that geographical

segregation on the basis of income has increased since the 1970s, meaning it is likely that neighbourhood deprivation is now contributing to the social gradient. This suggests that it is not only income but the wider context of poverty that is associated with poorer mental health. Recent rises in levels of poverty in the UK therefore have the potential to increase mental health problems (Elliot, 2016) and exacerbate pre-existing inequalities. Understanding why the social gradient exists is complex and there are several competing hypotheses as to why mental illness becomes concentrated in more socioeconomically deprived populations. The following section will outline the research in relation to how the social gradient is produced and the possible underlying mechanisms behind this association.

### **Generating the Social Gradient**

***Social Selection:*** Also known as social ‘drift’, this theory proposes that the symptoms of mental illness result in worsened functioning and this in turn produces lower socioeconomic status, for example, through loss of employment or educational opportunities that might ordinarily maintain or enhance socioeconomic status. Status loss resulting from reduced employment or educational opportunities may occur directly from the impact of symptoms or through mechanisms of discrimination such as stigma, but fundamentally for social selection theory, the illness exerts a causal effect on socioeconomic status.

***Social Causation:*** Conversely, this hypothesis proposes that the social status of the individual exerts a causal effect on their development of a mental illness and may also later impact on other factors such as severity of symptoms and recovery. This means that individuals who experience socioeconomic disadvantage in the first instance are more likely to develop a mental illness.

The pathways are not necessarily mutually exclusive, and research has sought to identify the ways in which causation and selection processes impact on mental illness. In perhaps the most extensive study into the two hypotheses, Dohrenwend et al. (1992) sampled 2,741 second generation African and European Jewish immigrants in Israel using ethnic group to explore the relationship between

socioeconomic status and mental health. The authors state that levels of discrimination in this context are higher for Jewish people of African origin.

The study proposed that if the social causation hypothesis is correct and mental illness is produced by social factors related to being of lower socioeconomic status, then the increased discrimination experienced by African Jewish immigrants as a socially disadvantaged group would produce levels of mental illness in the pattern of a clear social gradient. Evidence for social selection would be identified if there were more European Jewish individuals (who hypothetically experience fewer social stressors) with a mental illness in lower socioeconomic status groups since it is the illness that causes the drift. In addition to this, more individuals with mental illness in the European Jewish group would be found in higher socioeconomic status positions because wealthier individuals may have the resources to prevent downward drift.

Using these criteria, the findings suggested that both social causation and selection were important, but the effects of the social context differed depending on the type of illness. In this analysis, schizophrenia was found to be associated with downward drift whilst depression, anti-social personality disorder and substance misuse followed a pattern of social causation.

Differences in causal pathways by diagnosis have been replicated in further studies. Samele et al. (2001) conducted an analysis of employment data from 708 individuals experiencing severe psychotic illness to determine whether they had experienced social selection (drift) as a result of their illness. Data was compared from 'best ever occupation' of the individual to employment status at two year follow up and downward social drift was evident during this time period, although outcomes were worse for those who were continuously unemployed during the period of the study. Further to this, individuals who entered the study with lower socioeconomic status reported more severe psychotic symptoms. Without any change in socioeconomic status over the course of the study, it is difficult to ascertain whether social causation or selection is most prominent. This relates to a wider problem with the social selection hypothesis, in that it is not able to explain the mechanisms behind the association between lower socioeconomic status and mental illness for those who do

not experience drift. Similarly, the social causation hypothesis alone does not offer explanation as to the drivers of mental illness in those with higher socioeconomic status. In all likelihood, it may be that ‘simultaneous causation’ or a combination of both social causation and selection is the most effective explanation (Hanandita and Tampubolon, 2014).

### **Mechanisms linking socioeconomic deprivation and mental illness**

Alongside producing a greater likelihood of experiencing mental illness, socioeconomic deprivation is also associated with a greater severity of symptoms and lengthened recovery times, meaning a worsened prognosis. These findings by Samele et al. (2001) have been replicated in a number of different studies for both schizophrenia (Brown et al., 2000) and common mental disorders such as anxiety and depression (Weich and Lewis, 1998). Although in need of updating, research by Gift et al. (1986) found greater improvement two years after hospitalisation for individuals of higher socioeconomic status than those from more deprived backgrounds. Socioeconomic status in this study in fact had a greater impact on improvement of psychiatric symptoms than traditional indicators of social inclusion and recovery such as finding employment and building a social network. Access to financial resources may have acted as a protective factor here, ensuring the person could make a full recovery at home before returning to the stressors of everyday life. Higher incomes do not always mean more positive outcomes though and Agerbo et al. (2001) found that of individuals admitted to psychiatric inpatient units, those with a higher income were at greater risk of completed suicide. Again, however, financial resources could be implicated here, by enabling individuals to remain in the community for longer before hospitalisation.

Evidence that shows differential severity of symptoms and recovery outcomes by socioeconomic status would suggest that there are mechanisms producing in socioeconomically deprived groups not only a greater concentration of illness but also worse forms of the condition itself. Research indicates that financial strain can impact significantly on individual mental health so that whilst individuals across social classes experience stressful situations, it is argued that those who are economically secure have more of a buffer, resulting in less of a ‘range and quantity’

of stressors (Rogers and Pilgrim, 2010). Financial strain may hinder recovery because the stress associated with trying to manage on a low income has the potential to exacerbate or prolong existing symptoms.

In a study of 2,406 respondents of the Adult Psychiatric Morbidity Survey, Skapinakis et al. (2006) found that those who reported financial difficulties at baseline had a significantly increased risk of developing a mental illness during a follow up clinical interview. Those who were unemployed at baseline had the worst outcomes, being 4.45 (95% CI: 2.54-7.70) times more likely to develop a persistent common mental disorder during the course of the study. Further evidence that financial strain negatively impacts on mental health comes from Zimmerman and Katon (2005), who studied data from the 1992 US National Longitudinal Study of Youth. They concluded that although income is strongly associated with depression, this is because it acts as a proxy for variables related to income such as financial difficulties and employment status. In a more recent study using two waves of the National Epidemiological Survey and a nationally representative North American sample of 34,459 people, Businelle et al. (2014) identified that stress is a primary pathway by which socioeconomic conditions indirectly impact on mental illness.

Alongside the influence of singular stressful events, individuals may also experience a cumulative effect of social disadvantage through multiple difficult life circumstances that add up to produce mental illness (Adriaanse et al., 2014). Multiple social disadvantages can also lead to a clustering of difficulties within families (Agerbo, Qin and Mortensen, 2006), which may offer a challenge to currently popular genetic explanations of illness.

Taken together, these studies indicate the importance of ensuring that individuals across the income spectrum are able to achieve economic security, regardless of their employment status. Although health inequalities research has clearly made significant progress in documenting and understanding the links between mental illness and socioeconomic deprivation, there is still little understanding as to why this association remains as strong today as in the past. Whilst the broader social, historical and political context is sometimes discussed in relation to stigma, in mental health inequalities research it is often neglected. The tradition of mental



health care and treatment in the UK has implications for the relationship between socioeconomic status and mental illness, particularly when this is considered in relation to wider economic changes. The next section will document and discuss this broader context and how this may contribute to understanding these continuing links.

### **2.3. Deinstitutionalisation and community integration**

The first dedicated mental health hospital in England, The Bethlem, dates back to the 1400s (Historic England, 2018) with the large-scale adoption of the asylum model occurring by the 1800s (Hewlett and Horner, 2015). Often situated outside of community life both physically and socially, asylums functioned as total institutions in which people with mental illnesses were entirely segregated (Foucault, 1967).

Until the 1950s in the UK, people requiring hospitalisation for their illness continued to receive treatment in institutions, but then criticisms of this system began to gather pace. Theorists such as Goffman and Laing commented on the detrimental psychosocial impact of prolonged hospitalisation via the process of ‘institutionalisation’ in which individual identity becomes lost in the rules and requirements of life in the total institution (Goffman, 1968). Asylums were viewed as environments of social control that were heavily implicated in the unnecessary medicalisation of distress (Laing, 1960). Whilst it has since been argued the focus on ‘liberating’ people with mental illnesses that accompanied such ideas constituted a somewhat paternalistic approach (Poole et al., 2013), the deinstitutionalisation movement did transform mental health care across Europe and North America.

In the UK, the influence of the deinstitutionalisation movement coupled with the creation of new antipsychotic medications and welfare benefits, produced a reduction in hospital admissions and a rise in community-based treatment from around 1954 onwards (Hewlett and Horner, 2015). This model was later expanded to include measures such as the introduction of community mental health nurses and the integration of NHS and social care services for mental health. Services for the majority of people with mental health problems have been provided in this way ever since. By 2014 in England, 963,520 individuals were in contact with secondary

mental health services and of these, just 2.4% were inpatients in psychiatric hospitals (Hewlett and Horner, 2015). The deinstitutionalisation model continues to exert influence across the world and remains an important indicator of the functioning of mental health systems. It is used to monitor whether countries are moving towards more humane models of care for people with mental illnesses (World Health Organisation, 2013).

Whilst it is indisputable that reducing incarceration should be a priority, deinstitutionalisation is based on the assumption that community-based models of care will offer guarantees of human rights, independence and greater social integration. Yet life for people with mental illness in the community has frequently failed to meet these expectations. Over fifty years after deinstitutionalisation in the UK, people with mental illnesses continue to experience inequalities in education and employment (Ngu et al., 2010) and for some illnesses, a life expectancy up to 25 years lower than the general adult population (Department of Health and Social Care, 2011). Evidence of a change in public prejudice over time remains mixed, despite repeated wide reaching anti-stigma campaigns (Dinos, 2014; Evans-Lacko et al., 2014; Angermeyer et al., 2014) and as outlined in the previous section, mental illness remains strongly associated with socioeconomic disadvantage (Marmot, 2010; Rogers and Pilgrim, 2010).

Modern accounts of the care and treatment of people with mental illness are frequently contextualised by deinstitutionalisation but there is a parallel history that is often neglected. This history shows that socioeconomic disadvantage is not new for people with mental illnesses, but the continuation of a pattern that has been documented over many years. From the 1920s onwards in the UK, models of care began to focus on rehabilitation and the number of voluntary outpatient services started to increase (Hewlett and Horner, 2015). As early as 1938 researchers had identified patterns of ‘ghettoisation’ in which people with mental illnesses were concentrated in low income, inner-city areas (Philo, 1997) and in 1958, Hollingshead (1958) undertook a comprehensive study into socioeconomic status and mental illness in the USA, one of the first to identify that lower socioeconomic status was associated with a greater risk of mental illness and a lower likelihood of receiving treatment.

This study was undertaken early in the deinstitutionalisation process and once services for people with mental illness had transitioned into the community, it would be reasonable to assume that this association would be weakened as support networks became more embedded, but individuals who left hospital following deinstitutionalisation were settled into communities with limited frameworks for understanding mental illness. Newcomers were felt to be unpredictable, aggressive and to have an ‘unnatural interest in children’ (Poole et al., 2013).

The ‘Not in My Back Yard’ (NIMBY) phenomenon has been well-documented in relation to people with mental illness, meaning that whilst public opinion may favour community based support services from a treatment and care perspective, attitudes towards such services being located in close proximity are very different. A recent example is provided by the debate between local residents and the charity Rethink over the development of a short stay service for people experiencing mental health crisis in a residential area of Sheffield which received over thirty planning objections (Sheffield City Council, 2012; The Sheffield Star, 2012), a number of which cite unpredictability, risk of violence and the proximity of the facility to local children as concerns. The NIMBY effect has led to mental health treatment and residential facilities being placed disproportionately in more disadvantaged neighbourhoods (Link and Phelan, 2001; Thornicroft, 2006). Coupled with the higher reliance on social security benefits and social housing associated with long term disabling conditions, individuals with mental illness have experienced ‘geographical segregation’ as a result of these factors (Livingston, 2013; Dear and Wolch, 1987). Social housing itself is also associated with the stigma attached to multiple marginalised groups being concentrated in particular neighbourhoods (Vassenden and Lie, 2013). In this way, the stigma attached to mental illness promotes patterns of socioeconomic exclusion.

Community integration relates to the interaction between communities and individuals and to how the conditions for social inclusion or exclusion are produced (Nelson et al., 2014). This includes not only being physically located in a community, but also being an active participant and having opportunities to broaden social networks (Wong and Solomon, 2002). Physical integration relates to spatial location, both in terms of where housing is situated within neighbourhoods and

proximity to other people and facilities. Psychological integration refers to the individual level processes that contribute towards a sense of belonging to a community. Social integration is related to wider features of the neighbourhood such as opportunities to build social networks, acceptance by other residents, safety, and being able to live without stigma and discrimination (Nelson et al., 2014). Each of these components is evidenced as being associated with quality of life and life satisfaction for people with mental illness in the community (Nelson et al., 2014) although studies to date have mainly focused on the experiences of people living in forms of supported housing (Wong and Solomon, 2002; Yanos, 2007).

Further to this, the physical location of housing and ‘neighbourhood social climate’, including perceptions of tolerance, belonging and experiences of stigma, directly impact on levels of psychological distress (Kloos and Townley, 2011). Such findings are unsurprising since clearly feeling safe, accepted and having access to appropriate facilities are ambitions for most people in relation to where they live, but these basic needs may also be more difficult to achieve for those with a marginalised status and who are living in poverty, through lack of access to the resources that enable community participation. The challenges here are clear. Whilst there has been an active drive towards community-based support for people with mental illnesses, most notably enshrined in law by the NHS and Community Care Act (1990), where the conditions for social inclusion have not been fully met, the experience for a sizeable number of people continues to be one of poverty, exclusion and social segregation.

Interventions focused on increasing opportunities for social contact between people with and without mental illnesses have the greatest potential for reducing stigma compared to other initiatives such as those providing education and awareness (Thornicroft et al., 2016) but it is perhaps telling that there has been a need to design such interventions rather than allowing levels of social contact to improve organically over time. In fact, having a health condition, illness or impairment still remains associated with having lower levels of social contact with others (Office for National Statistics, 2015). Marmot (2010) suggests that links between area level socioeconomic deprivation and higher rates of mental illness follow a trend dating back over forty years in which people with low incomes have become increasingly

segregated into particular neighbourhoods. Community integration therefore relies not only on individual social interactions, but also on societal factors to produce the conditions for marginalised groups to be socially included.

The aim of community integration is reflected in the ideals behind the recovery model, now widely used to formulate care for people with mental health difficulties. The recovery model is person-centred, focusing not on cure but on coping strategies for symptoms, and promotes social inclusion through employment, education and social contact (Repper, 2003). Whilst clearly these are potentially positive outcomes, critics have argued that the recovery model is a misrepresentation of personal autonomy because it seeks to individualise problems of social inclusion (McWade, 2016). If a person is unable to achieve their goal of employment, for example, or experiences difficulties coping with their illness, this may be viewed as having more in keeping with a lack of personal resilience than the situation itself, which is potentially stigmatising for individuals. At the same time, wider barriers to social inclusion may then be overlooked. It is perhaps interesting that individualised explanations of recovery from mental illness have coincided with a rise in individualised explanations of illness, such as the biogenetic explanations discussed in Chapter 1.

At present, the gap in the employment rate between people in contact with secondary mental health services and the general population is approximately 67.4% (Public Health England, 2018) and people with mental illnesses form the largest group of welfare claimants in the UK currently (Moncrieff and Viola, 2016). This suggests that there are wider barriers to employment for people with mental illnesses, which could include the health condition itself and difficulties associated with access to labour markets. It also means that access to appropriate social security, to reduce the harmful impacts of socioeconomic deprivation described here is key.

## 2.4. The Wider Economic Context

Economic policy changes across the UK and Europe over the past thirty years have led to a greater focus on lower regulation of financial markets and increased globalisation of trade (Schrecker and Bambra, 2015). Over the same time period, nations that have all but eliminated material deprivation have seen rising inequality and a significant increase in mental illness for both children and adults, leading to a growing concern that these economic approaches, termed neoliberalist policy, are having a detrimental impact on mental health (Dorling, 2015; Schrecker and Bambra, 2015). Whilst it is difficult to prove an association at this ecological level, there are several reasons why researchers have suggested that changes to rates of mental ill health may be associated with a shift towards neoliberalism.

More generally, theories surrounding the causes of mental illness are now dominated by biomedical explanations, for example, imbalances in neurotransmitters or genetic vulnerabilities (Brown and Baker, 2012). Esposito and Perez (2014) argue that neoliberal economics has led to a ‘commodification of mental health’ in which biomedical explanations shift focus away from the wider social determinants of illness and towards individual attributes. This is in keeping with the theories and evidence discussed in the previous sections. Esposito and Perez (2014) suggest that the damaging effects of neoliberalism such as increased alienation and unattainable material wealth are ignored and at the same time, biomedical explanations have produced a proliferation of individualised medical treatments that benefits a powerful pharmaceutical industry, particularly in countries with privatised healthcare in which products can be marketed direct to consumers. Since the explanation and the solution are both portrayed as scientific and therefore objective, they are viewed as being above reproach. Alternatively though, it could be that biomedical explanations and the rise in the use and diversity of pharmaceutical treatments simply represents scientific progress.

Increases in the use of such treatments may be a reflection that greater numbers of people are developing mental illnesses over time and it may be a result of overdiagnosis, the two not being mutually exclusive. The controversy surrounding

overdiagnosis has been reignited most recently with the release of the latest Diagnostic and Statistical Manual (DSM-V), a diagnostic tool for mental illness used mostly in North America, which some have suggested goes further than ever before in unnecessarily medicalising certain behaviours (British Psychological Society, 2011). Both increased numbers of people experiencing mental illness and overdiagnosis could be suggestive of the influence of the wider socioeconomic climate on individual mental health.

Standing (2014), cited in (Schrecker and Bambra, 2015) argues that the episodic nature of some mental illnesses can make it difficult for people to find stable work, meaning a greater likelihood of ending up in the ‘precariat’, a social group who are subject to insecure forms of employment and in-work poverty. Meanwhile, he suggests that psychological interventions such as cognitive behavioural therapy have been developed as a ‘fast cure’ that medicalise what may be considered understandable reactions to this economic insecurity, ensuring problems remain individualised rather than being related to the wider socioeconomic structures that produce this insecurity. When neoliberal labour markets are also accompanied by selective social security arrangements, lines are drawn between those who are deserving and undeserving of financial support, leading to stereotypes of ‘the deviant poor’ (Albrekt Larsen and Dejgaard, 2013). With such stereotypes, poverty is approached with disgust and blame (Lawler, 2005).

Individualisation and the emphasis on meritocratic ideals associated with neoliberal narratives can also lead to distress in other ways, especially since they are not always accompanied by equality of access to opportunities. In an extensive exploration of the impact of social inequality, Dorling (2015) argues that neoliberal forms of economic competition exclude ever more of the population whilst accompanying narratives suggest that lack of success is the fault of the individual. This is emphasised through vehicles such as advertising, the media and politics alongside a message that ‘despair is inevitable’ in society. Perceived failure may lead to an internalised sense of self-blame and anxiety, therefore producing distress and mental illness.

This has parallels with self-stigma discussed earlier in the literature review and current approaches to mental health care may have unwittingly played into these ideals. By focusing on indicators of social inclusion such as employment and by concentrating responsibility for recovery on the person, without recognition of the wider economic barriers or social causation focused explanations of illness, any failure to achieve these goals may be viewed as the fault of the individual. Where a person is unable to work due to mental ill health, they may encounter self-stigma and stigma from others because they are not able to fulfil meritocratic ideals, therefore the socioeconomic context could produce an ideological basis for increased stigma. This competitive climate also evokes comparison with others, so that it is not only socioeconomic deprivation but social positioning that impacts on mental health.

### **Relative Deprivation and Subjective Social Status**

This chapter has established with evidence of the social gradient that effects of socioeconomic status on mental illness exist above the level of absolute poverty. In fact, there is evidence that mental health problems in high income countries are 1.3 times those of lower income countries (Whiteford et al., 2015), suggesting that economic factors exert an influence beyond material deprivation.

Subjective social status is a relative measure that focuses on the social context of the individual and where the person perceives themselves as being ranked in the wider socioeconomic structure. It is culturally specific and based on ‘explicit social comparisons’ (Adjaye-Gbewonyo and Kawachi, 2012). Evidence suggests that subjective social status is a strong predictor of outcomes across a range of health conditions, including objective measurements such as cortisol (used to test stress levels) and self-reported health measures such as general health, well-being and mental health difficulties (Prag, Mills and Wittek, 2016). In a review of the literature on subjective social status and health, Euteneuer (2014) suggests that one of the reasons relative measures of social status may be more effective predictors than objective measures, is that in choosing where to place themselves on a social scale, individuals will ‘cognitively average’ a range of indicators such as their income, occupation and education to produce a single measure. Typically, despite being interrelated these indicators are often used as distinct categories. In this review,



longitudinal survey results revealed that individuals who placed themselves at a lower socioeconomic level were four times as likely to experience a decline in self-reported health and only half as likely to recover as those with higher subjective social status. These findings suggest that how a person perceives their financial situation has important implications.

Further supporting these findings, Adler et al. (2000) found both psychological and biological effects for those with lower perceived social status. These included higher levels of stress and reduced physiological adaptation to cortisol alongside symptoms of low mood such as negative affect; pessimism; and a reduction in sense of control and ability to cope. Evidence of a relationship between stress, low mood and lower subjective social status also provides further support for the idea of stress as a mediator in the relationship between socioeconomic status and mental health. There has been some concern that individuals with depression may exhibit a cognitive bias, producing greater negativity in both self-reported social status and mental health and thus confounding this relationship, although generally temporary forms of low mood have not been found to exert such an effect (Euteneuer, 2014).

In some ways, subjective social status can be problematic because it does not define who exactly individuals are comparing themselves to. A usual measurement tool involves respondents rating their social status on a scale from one to ten, in which ten represents those who are most affluent in that particular society. In the case of the MacArthur Scale of Subjective Social Status, for example, individuals place themselves on a visual 'ladder' in relation to their occupation, level of education and income as a single measure, the benefit of which is that a visual representation enables the tool to be used across different populations (Giatti et al., 2012) although the meaning of the scale to each person remains unclear. Comparisons could, for example, refer to the person's own social network; neighbours; society in general or specific affluent individuals such as celebrities (Adjaye-Gbewonyo and Kawachi, 2012). Overall though, in countries where social stratification is more entrenched, it is intuitive that the effects of subjective social status will become more salient because comparisons with others will carry greater importance. Here heightened stress derived from social comparisons may contribute to worse mental health outcomes.

In an analysis of national surveys exploring twelve-month prevalence of mental illness, Pickett and Wilkinson (2010) found that although variation existed in absolute rates across countries, there was a clear relationship between greater income inequality and higher prevalence of mental illness. Furthermore, mental health was worse not only for the most deprived but for all members of these societies when compared to more equal nations. One proposed mechanism for this is that the status competition caused by larger gaps between rich and poor produces increased stress and anxiety, subsequently leading to higher levels of distress and mental illness (Wilkinson and Pickett, 2018). Much of this evidence is focused on high income countries since this is where relative deprivation has a greater impact than absolute levels of poverty; however, these findings have also been replicated across Indonesia by Hanandita and Tampubolon (2014), who found effects of income inequality on mental health in the context of both relative and absolute deprivation.

In an extensive systematic review of the association between inequality and schizophrenia, Burns, Tomita and Kapadia (2014) explored data published from 1975 to 2011, finding 107 incidence rates of schizophrenia in 26 different countries which were modelled using the Gini coefficient, a measure rating countries based on values between 0 and 100, with higher values representing greater income inequality (The World Bank, 2016). Higher levels of income inequality were consistently associated with a higher incidence of schizophrenia, leading the authors to conclude that countries with a greater gap between rich and poor may be at risk of higher rates of schizophrenia.

Johnson, Wibbels and Wilkinson (2015) provide further support for this finding in their analysis of the impact of income inequality on psychosis. Responses from the World Health Organisation Mental Health Survey (2002-2004) including 249,217 individuals from fifty countries were analysed for experience of four psychotic symptoms during the preceding twelve months. Several measures of income inequality were included, the Standardised World Income Inequality Database, a form of Gini coefficient used to measure national level inequality across countries and the 90-10 measurement of how concentrated economic resources are at the top of a particular society. Absolute poverty was controlled for alongside the type of political regime since this could arguably confound responses to certain questions,

for example, whether the individual reports a fear of persecution which in some cases may be a symptom of psychosis but could also be a lived experience. The findings demonstrate that for every 1% increase in wealth at the top percentile of a country, there was a 1.28% increase in the overall psychosis score (summed from the four individual symptoms) with similar findings for the Gini coefficient. There is also evidence that social mobility is lower in more unequal countries (Dorling, 2015) and that this can impact on health by producing fixed health inequalities between generations. In a study of European countries, Campos-Matos and Kawachi (2015) found that lower social mobility had a detrimental impact on health whilst greater social mobility exerted a protective effect.

Further evidence that relative social position can impact on health comes from research on socioeconomic incongruence, in which there is a disparity between the socioeconomic status of individuals and those around them. Using longitudinal data from mothers in the Millennium Cohort Study, Albor et al. (2014) explored whether living in a socioeconomic context incongruent to an individual's own social class impacted on a range of health outcomes, including anxiety, depression and self-esteem. They were able to demonstrate evidence of a social gradient in health from low to high socioeconomic status as well as a negative effect for incongruence among high status mothers living in lower status neighbourhoods. The same effect was not found for lower status mothers living in higher status neighbourhoods although the authors point out that the number of individuals in this sample was very low, itself a reflection of socioeconomic segregation within the UK. Any positive health effects of poorer mothers living in poorer neighbourhoods (congruence) may also be counteracted by the levels of material deprivation.

Although national level associations are not always reflected in the experience of individuals, the wealth of evidence from different countries and across different types of illness does suggest a patterning by income inequality in rates of mental illness. Income inequality also helps to explain why rates of mental illness are elevated in high income countries, despite that there is less absolute poverty.

## **2.5. Conclusion**

This chapter has demonstrated that there are clear links between socioeconomic status and mental illness at the individual, area and societal levels. Alongside the impact of illness itself on life chances, barriers to social inclusion grounded in the historical, social and political context may have also led to continued disadvantage for people with mental illnesses in relation to both income and wider experiences of poverty.

Further to this, wider economic conditions have exacerbated marginalisation and social exclusion. Individualised explanations of both mental illness and poverty have centred the blame for continued disadvantage on personal failings whilst neglecting some of the wider social, political and historical context discussed here. Where blame becomes individualised, there is the potential for increased stigma at the intersection between poverty and mental illness. Unequal societies, in which relative social status becomes more salient, feed into these narratives. The legacy of exclusion and socioeconomic disadvantage, alongside the effects of poor health, has led to a significant number of people with mental illnesses needing access to social security. The role of employment and the welfare system will be discussed further in Chapter 3, which seeks to situate the factors described here in the post-2007 recession context.

## **Chapter 3: Mental Illness and stigma in the post-recession context**

### **3.1. Introduction**

The evidence discussed in the previous chapter suggests that there are strong links between mental illness and socioeconomic deprivation, that this association is mediated by stress produced by financial insecurity and that the broader economic context has a demonstrable impact on individual mental health. Chapter 3 will consider how socioeconomic context relates to the stigma associated with mental illness. It will argue in particular that welfare reform measures taken since the 1990s are at odds with the drive towards increased social inclusion for people with mental illness because they have been accompanied by a contracting of financial support and an increase in stigmatising narratives, both of which act to increase social exclusion. Changes to labour markets and public spending in response to the Great Recession may have further exacerbated the socioeconomic difficulties and stigma experienced by people with mental illness.

### **3.2. Social security: Providing a financial safety net**

The dismantling of institutionalised mental health care and the shifting of services towards community support created a need to ensure housing and income provision for those leaving long term hospitalisation and for those unable to work due to mental ill health (Hirst and Sainsbury, 1996). Carpenter (2009) argues that the context of rapid closures of mental health hospitals in the 1980s, followed by several high profile incidents of violence involving ex-patients and in parallel an increased focus on human rights during the 1990s, has led to a mental health system that is confused, on the one hand seeking to promote personal autonomy and independence whilst on the other hand introducing paternalistic measures to satisfy public concerns about risk. The updated 2007 Mental Health Act, for example, includes a number of restrictive principles such as provision for supervised community treatment, in which an individual can be subject to controls whilst living in the community and recalled to hospital at any time. For those subject to detention under the Mental Health Act, there is now a requirement to provide aftercare (Carpenter, 2009) which may include community mental health service follow up, housing and other forms of support. For those who admit themselves to hospital voluntarily, however, there is no such provision in place (Mental Health Act 1983/2007). This means that although in recovery from illness, after leaving hospital a number of people are not automatically entitled to support in the community which may hold implications for financial security. Although there are clear benefits to adequate housing and employment support, for those recently discharged or otherwise, Glover-Thomas (2002) suggests that these needs have frequently not been met for people with mental illnesses living in the community, leading to poverty and homelessness. In 2014, 80% of people who were homeless in the UK reported experiencing a mental health issue, with 26% reporting that mental illness was the cause of their homelessness (Mental Health Foundation, 2018).

Similarly, there have been changes to the financial support available to people who are unable to work due to mental ill health (Figure 3 details the types of payments available to people with disabling health conditions). In the UK, whilst the 1970s and 80s saw the expansion of both earnings replacement benefits and extra-cost benefits for people unable to work due to ill health, by the 1990s coverage began to contract and tougher eligibility criteria were introduced (Burchardt, 1999).

Figure 3. Categories of benefits applying to people with disabling health conditions (Burchardt, 1999)

Compensatory benefits: Paid to those who become sick or disabled as a result of 'serving the nation' – military or occupational capacity, e.g., industrial injuries disablement benefit, war disability pension.

Earnings replacement benefits: Provide an income for individuals unable to earn as a result of sickness or disability.

Extra-cost benefits: Provide help towards additional costs incurred as a result of disability, tax free and not means tested.

Means-tested benefits: To top up income, dependent on certain factors such as number of people in household, not primarily disability benefits but disabled people may receive, eg, housing benefit, council tax benefits.

Following the replacement of Invalidity Benefit with Incapacity Benefit in 1995, eligibility assessments no longer included labour market factors when determining capability for work, so that tests centred instead on individual ability to work, regardless of the likelihood of gaining employment (Burchardt, 1999). Meanwhile, the extra-cost benefits Attendance Allowance and Mobility Allowance were combined in 1992 under Disability Living Allowance and differential rates of pay were introduced (Hirst and Sainsbury, 1996). From 2008, Employment Support Allowance (ESA) replaced Incapacity Benefit.

In addition, since the 1990s, conditionality has increasingly been incorporated into welfare systems, making entitlement to social security payments contingent on certain requirements, through mechanisms premised on 'correcting' claimant behaviours and the application of a formalised sanctions regime (Dwyer, 2016). The introduction of ESA signalled a shift in conditionality, incorporating claimants who would previously have been in receipt of incapacity benefits and not necessarily subject to any conditions on their entitlement (Dwyer, 2016). Practically, the introduction of ESA meant an extension of conditionality for the first time to claimants with disabilities and long-term health conditions.

Benefit sanctions are penalties that are imposed when a claimant does not meet particular conditions placed on their entitlement and this results in a loss of income for a pre-specified time period (National Audit Office, 2016). Sanctions currently



have two parts, an open-ended period where the sanction remains in place until the person meets the original requirement, with an additional fixed part of between one week and four weeks in duration depending on whether or not the claimant has been sanctioned previously (Gov.uk, 2016), although there have been multiple iterations since their introduction and further changes under Universal Credit (Dwyer, 2018). Sanctions apply to those claiming Jobseekers Allowance (who have been found ‘fit for work’ following a Work Capability Assessment) and ESA claimants in the Work-Related Activity Group.

Notwithstanding the current migration of claimants to Universal Credit which was largely outside the scope of this research due to timing, ESA has been the main unemployment benefit available to all adults aged between 18 and 64 in the United Kingdom since 2008. The following is summarised from information taken from Gov.uk, correct as of 2016-17 at the time of carrying out the research. These definitions are used because they provide accurate context for the findings detailed in subsequent chapters.

Following an initial telephone application, the majority of individuals wishing to claim ESA are invited for a face to face Work Capability Assessment (WCA). Up until the WCA takes place, applicants receive a reduced rate of ESA by submitting regular ‘fit’ notes obtained through their GP surgery.

The WCA is designed to assess the ability of the individual to undertake paid employment by focusing on their capability to undertake daily living tasks and uses a points-based scoring system. There are three possible outcomes following a WCA:

**Support Group:** Individuals who are assessed as being unable to work due to difficulties with their health are placed into this group. There are no requirements to look for employment and this is time limited based on the hypothetical ability of the person to return to work in the future, for example, the person may be re-assessed after a two-year period depending on their health condition.

**Work Related Activity Group (WRAG):** Individuals placed in this group are assessed as having the ability to return to work in the near future but in need of support to do so. There are mandatory requirements attached to this outcome to attend courses, work focused interviews and other activities designed to build the skills necessary to re-enter employment. Non-adherence to these requirements may

result in benefit sanctions. Additional voluntary support options are also made available.

**Fit for Work:** Individuals who fall into this category are assessed as being immediately able to enter employment. They cannot claim ESA but are instead transferred to Job Seekers Allowance (JSA). JSA places the most demanding conditions on claimants, with mandatory requirements to actively seek work for a pre-specified number of hours each week and to attend any courses recommended by their individual job centre advisor. Failure to adhere to these requirements may lead to benefit sanctions.

Bambra (2008) argues that the changes brought about by the introduction of ESA created a deserving (severe illness or disability)/undeserving (sick but able to work) distinction between claimants, with some forms of illness being viewed as more deserving of financial support than others. Bambra (2008) predicted that public concerns about fraudulent claimants was likely to impact disproportionately on people with mental illness with the potential to reinforce existing stigma. Research on public attitudes towards benefit claimants from this time demonstrates a sharp decrease in the proportion of people endorsing the increase of benefits for disabled claimants and those who are unemployed suggesting a hardening of attitudes, whilst extra funds for child benefit and pensions were broadly supported (The Economist, 2008).

Alongside the potential for claimants to become implicated in existing narratives of fraud, several issues relating to mental illness mean that this type of condition does not necessarily lend itself well to eligibility assessments. Diagnosis is complex and not always clear, therefore leading to difficulties meeting set criteria to obtain financial support and secondly, mental illnesses are often episodic in nature, meaning capacity for work can fluctuate unpredictably (Royal Australian and New Zealand College of Psychiatrists, 2016).

This is not only applicable to ESA and employment-related benefits but also to extra-cost disability benefits. Disability Living Allowance was officially discontinued in 2013 and replaced by Personal Independence Payment (PIP). Whilst ESA and PIP represent different types of health-related income benefit – ESA is designed to support those who are unemployed whereas PIP is designed to cover the

additional costs associated with health conditions and can still be claimed if the person is working, eligibility is determined via very similar procedures. The migration of claimants from DLA to PIP and the implications for people with mental health conditions is discussed in further detail during subsequent chapters.

The next section explores how the changes to health-related income benefits described here and welfare reform more broadly, have impacted on people with mental health conditions in the post-recession period.

### **3.3. The post-recession context**

Fundamental securities such as housing and an income for those who are unable to work contribute to individual mental health and where these are insecure, to mental illness through mechanisms of financial strain and stress. Employment has clear benefits for mental health and promotes social integration, but employer discrimination and competitive labour markets contribute to a ‘double jeopardy’ for people with mental illness, in which the stigma associated with mental illness and of unemployment intersect and produce further difficulties in gaining work (Stuart, 2006). Conversely, a more recent study of employer discrimination in Belgium found that a diagnosis of depression impacted on the chances of receiving a positive outcome from job applications but that this was similar to a person without depression who had been unemployed for the same time period, suggesting it may be periods of unemployment rather than a diagnosis of depression per se that is problematic for employers (Baert et al., 2016).

The global recession of 2007 had a demonstrable negative impact on the employment opportunities of people with mental illnesses across Europe (Evans-Lacko et al., 2013), although whether this was due to contracting labour markets or stigmatising attitudes, or both is not clear. There are well-documented links between increases in suicide rates and periods of economic recession (Case and Deaton, 2015) but recent evidence from Barr, Kinderman and Whitehead (2015a) suggests that an upward trend of mental illness has continued in the UK despite apparent economic recovery, in fact reaching a 13 year high in 2013. This suggests there may

be elements of the post-recession climate that are continuing to impact on mental health.

Using data from the Quarterly Labour Force Survey, Barr, Kinderman and Whitehead (2015a) analysed both self-reported mental health and objective measures of illness such as localised suicide rates and anti-depressant prescribing between 2004 and 2013. They found increased prevalence of mental illness at a higher level than would have been expected if 2004 trends had continued after the recession, with a twofold increase for those from lower educational and socioeconomic backgrounds, suggesting a more concentrated impact amongst more socioeconomically deprived individuals. It was estimated in fact that within local authority areas, each percentage increase in unemployment led to a 0.15% increase in mental illness and a £10 reduction in median wages produced a 0.03% increase. Most notably however, they found that the economic trends were unable to explain 64% of the increase in prevalence. The researchers suggest one explanation for this may be that whilst levels of employment have increased with economic recovery, those from lower socioeconomic backgrounds have entered more precarious forms of employment, for example, zero-hour contracts.

These types of employment are often insecure and since the availability of work is unpredictable, could create stress and financial strain. In fact, as Schrecker and Bambra (2015) point out, it is not only loss of income that is materially difficult for individuals in such situations but the stigma, loss of self-worth and relative deprivation that is also attached to insecurity and unemployment. This acts as a pathway for difficult economic conditions to produce mental illness (Rogers and Pilgrim, 2010). Aside from the impact of changes to employment, Barr et al. (2015a) suggest that recent welfare reforms have affected socioeconomically deprived individuals the most and cite a reduction in incomes and an increase in benefit sanctions as other possible reasons for the increase in mental illness. The reform of social security has perhaps contributed to intensifying the links between mental illness and poverty.

In support of this, further research conducted by Barr et al. (2015b) explored links in the UK between Work Capability Assessments and changes to mental health. Area level changes in mental health outcomes as indicated by suicide rates and anti-

depressant prescriptions were assessed for their association with local introductions of Work Capability Assessments and the proportion of claims being reassessed. The researchers found that across England, 590 extra suicides; 279,000 cases of self-reported mental health problems and 725,000 anti-depressant prescriptions were attributable to the work capability re-assessment process between 2010 and 2013. To ensure findings were not the product of ecological fallacy, a smaller multilevel analysis was conducted at the individual level in which the same association was present, and the researchers also tested that reverse causality was not present in the analysis. Mental health outcomes were also compared to other physical health conditions in areas during the same time periods and no increase was found. The authors cite reasons such as stress associated with the assessment, hardship following denied claims and prolonged periods without an income during the appeals process as possible reasons for their findings.

The Welfare Reform Act (2012) saw a series of further changes to the financial support available to people with health conditions in relation to housing, including the introduction of the social sector size criteria (more commonly known as the 'bedroom tax') and a cap on the total housing benefit available to any individual. A report from the English Housing Survey (2014-15) states that 3.9 million households in England live in social sector housing (provided by the Local Authority or a housing association) and half of these contain at least one person with a life limiting illness (Department for Communities and Local Government, 2016). Although it is not clear exactly how many people in this category have a mental illness, the report finds that 76% of households in which one person has a life limiting illness claim housing benefit and therefore any changes to housing benefit policy may impact on this group disproportionately. In 2008-9, 64% of social renting households had their rent covered completely by their housing benefit; this had reduced to 54% by 2014-15, meaning that many social renters were left with a deficit to make up (Department for Communities and Local Government, 2016).

This policy has had visible consequences for the social integration of marginalised groups. Historically, the social segregation of people with mental illness mainly occurred in deprived urban centres (Dear and Wolch, 1987) and recent evidence suggests that concentrated areas of people with disabilities continue to exist, but the

spatial landscape has shifted quite dramatically. In the British context, urban regeneration, coupled with rising property prices and a decline in social housing stock has led to a shift of poverty from city centres to the suburbs because of the greater affordability of housing there (Minton and Bailey, 2016). This has produced a substantial increase in suburban poverty which has particularly affected those who are reliant on disability benefits, having been more acutely affected by welfare reform and reductions in housing benefits (Hunter, 2014). The shift of poverty to suburbia has wide reaching effects on access to labour markets and for social cohesion (Minton and Bailey, 2016). The major consequence here is that social segregation is perpetuated in a more modern form.

The changes to housing policy discussed here are recognised as having a disproportionate impact on disabled individuals in a way that would be considered ‘indirect discrimination’ under the 2010 Equalities Act (Meers, 2016), however, policy makers are allowed to proceed via the caveat that extra payments are available to individuals who experience a shortfall in their rent on an ad hoc basis. ‘Discretionary housing payments’ are administered by local authority decision makers and the individual must make an application to receive these top up payments. Meers (2016) argues however, that this move from statutory exemptions for certain vulnerable groups towards awarding extra money on a case by case basis leaves many disabled people with an insecure level of income, since there is no guarantee that the payments will continue, and they are often awarded on a short-term basis, sometimes with conditions attached.

Meanwhile, localised approaches to public spending create difficulties in assessing the ‘cumulative impact’ of spending reductions on individuals who may be reliant on multiple agencies for support (Meers, 2016). This certainly applies to people with mental illnesses, who may be reliant on health, social care and housing departments to provide a holistic care package. Housing patterns would seem to suggest increased marginalisation as a direct result of these policies and further to this, Government guidance states that individuals who decline offers of social housing may be placed further down or temporarily removed from social housing waiting lists (Gov.uk, 2016) meaning that people may be required to accept whatever is available,

regardless of personal preferences, requirements or suitability of the property in terms of factors such as location.

Together this evidence suggests that the post-recession economic context, coupled with changes to social security may be associated with increases in mental illness in the UK population. For those who are not prevented from working due to illness, the likelihood of ending up in precarious forms of employment is now increased. Both insecure employment and changes to the availability of benefits have the potential to produce financial strain and stress by creating economic insecurity. The combination of changes to the welfare system in relation to both housing and income, has the potential to increase cumulative disadvantage and further strengthen the links between socioeconomic deprivation and mental illness at both the individual and area level (Elliot, 2016). Where the narratives accompanying such policies make deserving and undeserving distinctions, they have the potential to exacerbate existing stigma and further drive social segregation. In turn, this holds implications for social inclusion. In fact, given the barriers faced by people with mental illness socioeconomically, it is feasible that high levels of social segregation are acting as a more modern form of institutionalisation.

This can be hypothesised within Link and Phelan's model:

- Welfare system changes have created less financial support for people with a mental illness and the NIMBY phenomenon creates opposition to the siting of housing for individuals with a mental illness in more (socially powerful) affluent communities.
- Supported housing for people with a mental illness become disproportionately situated in more disadvantaged neighbourhoods. This occurs alongside social housing provision and low-priced rental properties, which may also act as resources for people with long term disabling conditions.
- Socioeconomic deprivation increases social and geographical segregation and acts as a form of institutionalisation.

- Status loss occurs, and the stigma initially associated with mental illness becomes associated with the cumulative stigma of being mentally ill, socioeconomically disadvantaged and a welfare system user.
- This leads to a cycle of disadvantage which has the potential to affect not only the person themselves but other family members and also future generations.
- Those in more affluent areas, who may be more likely to hold power and status in relation to policy making have more limited social contact with individuals experiencing mental illness.

As well as experiences of cumulative disadvantage, there has been a resurgence of negative public attitudes towards welfare claimants in recent years (Beresford, 2016). The latest British Social Attitudes survey did find a softening of attitudes, but it is not clear yet whether this represents a longer-term trend (Baumberg-Geiger, 2017).

Hansen, Bourgois and Drucker (2013) suggest that in countries where the welfare state is shrinking, there has been an increasing ‘pathologization of poverty’ focused on seeking out the deserving and undeserving poor. Treating poverty as an individual pathology that must be addressed by the state through coercive means is part of the ‘new paternalism’ approach known as ‘workfare’ (Ben-Ishai, 2012) that includes measures such as increased conditionality and the notion that rights to financial support are not automatic but come with responsibilities to act in particular ways, as directed by the state (Dwyer, 2004). In the UK, this includes measures such as requirements to look for work, and to attend work placements or employability courses, with payments sanctioned if claimants fail to meet targets. Whilst supportive measures to assist people into employment can be beneficial, this approach, premised on the idea that people in poverty will only be motivated through coercive means can be disempowering for claimants (Ben-Ishai, 2012). Schram (2000) suggests that welfare claimants have been equated with poor mental health and character in this context, so that poverty is explained as inherently individual and personality based, linked with ‘damaged people’ who must be corrected by the state.



Stigma is functional in welfare systems because it discourages prolonged or unnecessary claims by ensuring the person feels ashamed of their status as a welfare claimant and it is therefore central to the way some welfare systems operate (Baumberg, 2016). Certainly, stigma towards disabled welfare claimants has intensified over time in the UK. Research suggests that between 2004/5 and 2010/11, media coverage of disabled claimants became less sympathetic with a greater focus on fraud and dishonest claims (Briant, Watson and Philo, 2013).

Welfare reform narratives have been used to justify more stringent eligibility criteria, increased conditionality and a retraction of existing financial support by suggesting that claimants do not have an automatic entitlement to social security and must fulfil certain requirements in order to access this, by acting as a 'responsible' claimant (Dwyer, 2004). This approach equates unemployment with laziness and dependency. Grover and Piggott (2015) argue that the changes to welfare systems underpinning these narratives are problematic for disabled people, because although equality rights legislation exists in relation to work, less attention is paid to whether employers adhere to this and therefore are willing to employ disabled people, whilst at the same time there has been a shift towards authoritarian approaches in obligating disabled claimants to find and maintain employment.

Further to this, more recent evidence suggests that increased conditionality is not effective in moving people towards the labour market, whilst at the same time having a range of negative impacts on claimants (Dwyer et al., 2018). The transition from state financial support to employment may have positive health and wellbeing effects for people with disabilities (Curnock, Leyland and Popham, 2016) but responsabilisation is based on the assumption that claimants do not want to work, rather than that their health or labour market barriers prevent them from doing so. This approach has been questioned by academics and disability campaigners, with critics arguing that such measures have had a disproportionate and detrimental impact on people with disabilities (Taylor-Robinson, Whitehead and Barr, 2014; Patrick, 2012; Cross, 2013).

An investigation into welfare reform in the UK by the United Nations Convention on the Rights of People with Disabilities (CRPD, 2016) concluded that people with

disabilities appeared to be disadvantaged by changes in the welfare system and that claimants with disabilities were particularly impacted by the focus on benefit fraud, which has generated stigmatising narratives. On this basis, the report predicted a potential for rises in disability hate crime, which although it is not possible to directly link this to welfare reform based on current evidence, has occurred. Disability hate crimes reported to the police rose from 1,748 cases in 2011/12 to 5,558 in 2016/17 and whilst some of these changes may reflect improved recording measures (Home Office, 2017), this does represent a substantial increase over time.

There is a strong argument for dedicated research on the impact of welfare reform measures on claimants with mental illnesses. There is a significant employment gap between the general population and people with mental illnesses across Europe (OECD, 2012), suggesting that people with mental illnesses may be more likely to require state financial support. This is in addition to higher population rates of mental ill health. In 2014, 1.1 million people in the UK cited mental health as the primary reason for their welfare claim, the largest number for any one health condition (Moncrieff and Viola, 2016). The citing of mental illness as the primary reason for claims appear to be a trend that is increasing over time (Banks, Blundell and Emmerson, 2015; OECD, 2012) and recent figures suggest that around 54% of disabled people who are unemployed experience a mental health and/or a musculoskeletal condition (Department for Work and Pensions, 2016). This is a significant amount of people likely to be affected by any changes.

In parallel, the evidence available suggests claimants with mental illnesses may be subject to more acute forms of stigma compared to other claimants. Several interview studies on the lived experiences of welfare reform where claimants with mental illnesses have formed part of the sample have found that individuals feel that their illness is taken less seriously than physical health conditions and is viewed as less deserving of financial support (Garthwaite, 2014; Patrick, 2017). Similarly, Briant et al. (2013) found that whilst media coverage of all disabled claimants was broadly negative, this effect was particularly acute for people with mental health compared to physical health conditions. Moreover, an accompanying focus group study exploring audience perceptions of the coverage found that mentally ill

claimants were more likely to be perceived as fraudulent. This suggests that claimant perceptions of being viewed as less deserving by others may well be accurate.

In addition, O'Brien (2015) found that when people were primed to consider the financial burden of social security payments, they were less sympathetic towards hypothetical claimants overall but especially so towards a person with depression (compared to an individual with back pain) who was viewed as more to blame for their health condition and less in need of support. In a separate analysis of public attitudes, Thornicroft, Evans-Lacko and Henderson (2013) found that around a third of the British public disagree with the statement that 'most people with mental health problems want to have paid employment'. Where welfare reform narratives focus on dependency and promote a perception that the system is being overused, this has the potential to increase stigma towards all claimants but particularly those with a mental illness.

Alongside stigma, there is some evidence that claimants experiencing mental illness are experiencing increased financial disadvantage following recent reforms. Using freedom of information requests, Rethink Sanctions (Joint Public Issues Team, 2015) found that people with mental illness receive benefit sanctions at a higher rate than individuals experiencing other health conditions, with a sharp increase from 2012 onwards. There has been a rise in the use of food banks for all benefit claimants but disproportionately so for people with mental illnesses (Loopstra and Lalor, 2017) and people with mental illnesses have acutely felt the impact of increased conditionality (Dwyer et al., 2018), all of which could feasibly be linked. Concerns have also been raised that new eligibility assessments for ESA and PIP are not designed appropriately to assess the difficulties caused by mental ill health (Callanan, 2011; Abdul-Hamid and Bhui, 2014) which may also impact on uptake of financial support.

The potential for stigma and disadvantage described here may need to be addressed but more evidence is needed. At the time of designing the research for the thesis, only one qualitative study had focused solely on the lived experiences of claimants with mental illness following recent welfare reforms. This research interviewed individuals going through an appeals process for ESA and overwhelmingly found

that participants felt their difficulties were disbelieved or trivialised by assessors and that the assessment process itself produced increased stress (Shefer et al., 2016). Although useful in highlighting some of the potential issues experienced by claimants with a mental illness, the sample consists of claimants who specifically did not meet the criteria of assessors and so theirs may not be the experience of everyone undergoing these assessments. It also focused on one particular part of the claims process rather than underlying themes associated with the process overall.

Further to this, there is a need to explore how the broader socioeconomic factors outlined in the three literature review chapters impact on the stigma associated with mental illness. This is particularly important in the post-recession context, given the evidence that suggests the potential not only for increased socioeconomic disadvantage through labour market barriers and reductions in public spending but also in relation to accompanying narratives that may serve to exacerbate existing experiences of stigma.

### 3.4. Overall Research Aims

The aims of the thesis are as follows:

**A. To explore the relationship between micro level socioeconomic factors and the stigma associated with mental illness in the post-2007 recession context.**

This aim will focus on the association between individual socioeconomic factors and forms of stigma. Alongside individual financial circumstances, the role of the social security system will be explored because, as outlined in the literature review, this is a key source of financial support for people with mental illnesses.

**B. To explore the relationship between macro level socioeconomic factors and the stigma associated with mental illness in the post-2007 recession context.**

This aim will focus on understanding whether there are associations between broader socioeconomic structures and the stigma associated with mental illness. It is outside the scope of the thesis to explore all potentially relevant economic factors and so the research will focus on the salient factors that have been described here, including access to financial resources, public spending and financial barriers to social inclusion.

## **Conclusion**

Research to date has focused on addressing interpersonal forms of stigma whilst the underlying structural factors that produce the conditions for stigma to exist have been somewhat neglected.

Despite the transition towards community-based care and efforts to promote social inclusion, people who experience mental illness remain marginalised and disadvantaged. Whilst there is no doubt that reducing the mass hospitalisation of people with mental illnesses and moving towards community-based approaches represents perhaps the most positive revolution in approaches to care and treatment there has ever been, this has been accompanied by community experiences of socioeconomic disadvantage, inequalities and social exclusion.

Individualised ideological frameworks that situate mental illness and poverty as personal struggles whilst ignoring the wider socioeconomic context may be damaging and stigmatising to those they affect. Wider socioeconomic conditions can therefore impact on mental health in the same way that individual financial circumstances may produce the financial strain and stress that mediates the relationship between socioeconomic deprivation and mental illness. Welfare reform and the narratives that surround it feed into existing stigma, by promoting ideas of welfare dependency and fraud.

As a population more likely to be in need of financial support and whose difficulties may not be well understood, people with mental illnesses experience these effects acutely. This is already in evidence through increased social segregation and financial hardship, but further research is needed.

The next section will set out the methodology of three studies designed to address the research aims discussed in this chapter.

## **Section B: Methodology**

## **Introduction**

This section of the thesis outlines the research process for each of three studies relating to the overall research aims. The research uses a combination of qualitative and quantitative research methods and so each chapter in this section and the following results chapters is distinct and centred around one study in the series. The aim of this section is primarily to detail the planning and construction of the research design, to outline how I have dealt with methodological challenges arising during the process and to set out the final framework for each piece of research.

## **Epistemological and Ontological position**

This research is informed by a critical realist approach. Critical realism suggests that there are multiple realities to be discovered and as such incorporates ontological as well as epistemological concerns. Critical realism proposes there are three layers of reality – the empirical, referring to observable traces of events and experiences, the actual, the events and potentialities of events occur in certain contexts and the real, referring to underlying generative mechanisms driving the actual and the empirical (Bhaskar, 1975; Zachariadis, Scott and Barrett, 2013). It therefore focuses not only on empirical findings but on the underlying structures, power and causal mechanisms that enable social conditions to exist (Fletcher, 2017).

In the theoretical framework for this research provided by Link and Phelan (2001) and outlined in the previous section, the focus is not only on stigma at the micro level, but on the structures and social conditions that enable stigma to exist and thrive, therefore a critical realist approach is well suited to situating the research findings in this theoretical context. Generalisation takes on a different meaning to the traditional positivist definition here; it primarily asks whether individual level findings can be generalised to their broader underlying structures through causal mechanisms, using the process of retrodution (Danermark, 2002). Retrodution incorporates both inductive and deductive logic as part of an iterative process designed to explore and explain the underlying structures behind empirical research findings (Elliot et al., 2016). This means beginning with a theoretical framework for the research but moving back and forth between this and the themes emerging from



the findings to refine explanations of the data and seek information on causal mechanisms. It is an approach that eschews traditional positivist and constructionist paradigms by suggesting that there are layers of reality and different forms of knowledge, some of which are immediately knowable and some of which must be inferred by the researcher (Danermark, 2002). Knowledge is formed of two key domains; the intransitive which consists of objects that exist independently of individuals and the transitive, referring to the ways knowledge is interpreted and produced by individuals (Bhaskar, 1975).

Stigma, in all the forms discussed here is a complex phenomenon that is not always immediately visible and similarly, where individuals internalise and believe stigmatising narratives apply to themselves, stigma may manifest instead as, for example, low self-esteem without the person being aware of the underlying drivers or overtly naming this as stigma (Link and Phelan, 2001). It is important here therefore that there is space for researcher led inference that draws on and evidences theoretical background to explain the research findings; however, this approach potentially prioritises the voice of the researcher over that of the participants which may inadvertently contribute to disempowerment (Fletcher, 2017). Research that exacerbates disempowerment in an already marginalised population such as people with mental illnesses has the potential to be especially problematic. Shannon-Baker (2016) argues, however, that by taking into account multiple perspectives and realities when arriving at inferences, critical realism can be empowering because it embraces a diversity of viewpoints. The qualitative component of the thesis approaches this dilemma by foregrounding the voices of participants in the presentation of findings whilst offering theoretically based, researcher-led inferences when discussing the presence or absence of forms of stigma.

### **Critical Realism and Research Design**

Debates on the role of epistemology and ontology in research design are reflected in the different paradigms associated with particular research methods, for example, quantitative studies may traditionally use a positivist framework whilst qualitative research often follows interpretivist principles (Morgan, 2007) cited in Plano Clark and Creswell (2008), albeit there are nuances to both. This is fundamental to study

design because it determines what inferences the researcher can make from the data they have collected. Following either approach exclusively is potentially problematic for research using a critical realist perspective because of the assumption of different layers of reality previously discussed. Critical realism does not favour either qualitative or quantitative research, suggesting instead a ‘critical methodological pluralism’ (Zachariadis et al., 2013) in which the choice of research methods depends on using the best tools to uncover knowledge of the generative mechanisms. Consequently, there is no ‘hierarchy of knowledge’ in critical realism; it is the context (the actual and the real) in which the findings (the empirical) are situated that is important (Nairn, 2012) and this is used to inform understandings of causality (Shannon-Baker, 2016).

In this way, critical realism is well suited to research using mixed methods designs because qualitative and quantitative methods are viewed as having different but complementary functions (Zachariadis et al., 2013) and as such, critical realism is able to address the tensions between competing methodological paradigms found ordinarily in research using mixed-method approaches to data collection and analysis.

There are multiple approaches to conducting mixed methods research and these can broadly be categorised in terms of sequential designs – qualitative research informs subsequent quantitative research or vice versa, and concurrent or parallel designs in which qualitative and quantitative research is conducted more or less simultaneously (Teddlie and Tashakkori, 2009). The key underpinning principle of mixed methods research, however, is that the research findings are integrated through triangulation and there are varying ways in which this can be achieved (Teddlie and Tashakkori, 1998). Triangulation in mixed methods research can be used to confirm the validity and reliability of findings; to form a more complete picture of the realities emerging from the findings and to develop a more detailed understanding of processes, all of which are compatible with critical realist frameworks (McEvoy and Richards, 2006). Fundamentally, the purpose of research using a critical realist perspective is to understand the underlying causal mechanisms situated in the ‘real’ and to use these to develop and refine theories relating to the phenomena under study (Johnston and Smith, 2010).

## **The Research Process**

The research described in this thesis primarily followed a parallel mixed methods design but in keeping with a critical realist methodological framework, the studies were developed via an iterative process. This retroductive approach to study design is described by Zachariadis et al. (2013) in their framework for critical realist mixed methods research. According to this framework, there are four key components to the research process. Description/appreciation involves literature review and/or exploratory research that informs the initial study design. Second to this is the retroductive analysis phase, in which findings are considered in relation to theories and contextual factors. Through a process of abstraction, further hypotheses are developed and tested. The third phase – assessment and elimination involves comparison and integration of the research findings into a series of meta-inferences, taking into account context and underlying mechanisms. The final ‘action’ phase centres on dissemination of findings and where appropriate, recommendations for change.

In the thesis, the initial purpose of the research was to address the aim of understanding how different forms of stigma associated with mental illness might interact in the context of micro and macro socioeconomic conditions. The descriptive stage involved a review of the literature in which it was proposed that different forms of stigma (self, public and structural) may be linked in relation to mental illness and socioeconomic position. The research was framed in the post-2007 recession setting and it was hypothesised that a set of conditions associated with this socioeconomic context may be associated with the different forms of stigma.

Retroductive analysis was completed within a mixed-methods design. The research was planned iteratively in keeping with a retroductive approach, so that the initial interview study informed the administrative data analysis and both subsequently informed the cross-national comparative analysis. The theoretical model was reviewed at each stage to consider how each of the findings fit in with the forms of stigma outlined in the framework and used as feedback to inform the next stage of the research. The meta-inferences developed from the research and recommended actions (stages 3 and 4) are outlined in the overall discussion (Chapter 10).

Whilst beginning with a theoretical proposition to be tested and refined by generating evidence has been key to the thesis and has been helpful in setting out the research questions, finding the data to link individual outcomes to structural factors has been one of the biggest challenges of the research process. This has been especially true given that there is very little existing research that attempts to link together different forms of stigma at the micro and macro level, meaning that there was limited information to draw upon for study design.

Learning that theoretical propositions and the data to explore them do not always exist together has been a sometimes frustrating but ultimately useful part of the pedagogical process. More broadly, critical realist ontological assumptions about realities are potentially problematic when confronted with the practicalities of conducting research. The empirical is defined as the observable traces of the actual and the real, representing the tangible phenomena that can be studied by researchers and used to make inferences about underlying mechanisms and structures (Johnston and Smith, 2010). The empirical level, however, only includes phenomena on which there is data available and so limits the parameters of the actual and the real that it is possible to study. This means that whilst there may be several realities, there is a difference between what could potentially be discovered and what is, in reality, discoverable through research. In part, these challenges can be overcome by generating new data but where the research questions require population level answers; this is time and resource intensive.

In developing the research design, I have therefore drawn on a range of primary and secondary data sources to address the thesis aims and answer the research questions. The refining of the theoretical framework in response to these findings and the development of meta-inferences, alongside the challenges associated with this process, are explored further in Chapter 10.

## **Definitions of key terms**

### **Stigma**

The theoretical framework discussed in Chapter 1 proposes that stigma exists at the interpersonal and structural level and that these are interrelated. Stigma occurs at the interpersonal level through self-perception, either as internalised negative stereotypes or by awareness of such stereotypes, and as public attitudes. Stigma may also have structural drivers. Each of the forms of stigma are situated in a context of power (Link and Phelan, 2001).

### **‘Welfare Reform’**

Although narratives surrounding welfare reform may have common underlying themes, exploring each of the policy changes associated with these reforms would be far too broad for the scope of this research. To ensure my research remains focused, I will look specifically at health-related income benefits. Health-related income benefits are defined here as payments that specifically form part or all of the income that the claimant has in hand to financially support themselves and where eligibility is defined on the basis of health status. The welfare system is complex and there are many ways to research stigma and mental illness in this context, using health-related income benefits as a measure may not capture the experiences of all claimants but these do represent the main sources of social security available to people on the basis of having a mental illness. At the time of planning the research, Universal Credit (UC) was not widely available so has not been automatically included here but it is acknowledged that Employment Support Allowance in particular may be administered as part of UC, rather than as an independent payment.

### **Defining Mental Illness**

Although evidence suggests that experiences of stigma may differ across different types of mental illness, I have chosen not to define the research project by particular diagnoses at this initial stage. Designing studies around specific mental illnesses has the potential to limit the research because it will prevent comparisons across different conditions and the identification of underlying themes that traverse

particular diagnoses or categorisations, for example, between common mental disorders and serious mental illness. This type of categorisation is also potentially problematic in the context of eligibility for income benefits, since it is the impact of symptoms that is important rather than the diagnosis itself. Depression, usually categorised as a common mental disorder can also be a chronic, long term condition and psychosis, for example, may be transient, therefore separating claimants out in this way is not necessarily useful.

Further to this, it has been apparent during the literature review and planning stage of the research that data incorporating mental illness, stigma and socioeconomic status together is rare, and therefore self-limiting the project has the potential to produce difficulties with data collection and analysis, particularly in the case of qualitative research in which there is the potential that people with some forms of mental illnesses may be more difficult to recruit.

# **Chapter 4: Interview study design and research process**

## **4.1. Introduction**

This chapter details the planning and design of the first component of the research, an interview study designed to explore the lived experiences of welfare reform for people with mental illnesses. As discussed in the background section of the thesis, at the time of planning this study, limited evidence was available that explored the experiences of people with mental illnesses in this context with any depth. This has since changed, and more recent relevant research will be explored in the discussion section. The aim of this study, therefore, was to interview people with a range of different experiences, both in terms of illness and the process of claiming benefits, as a starting point for exploring some of the issues specific to this claimant group. The focus of this study is primarily at the micro level, on claimant experiences and perceptions of the viewpoint of others. As such it cannot provide direct evidence as to actual public attitudes but does explore the way interviewees feel they are seen by others. This study also aimed to give claimants with a mental illness a voice about their personal experiences because this is an effective way to understand and evaluate the impact of welfare reform on individuals. The chapter begins by outlining the study design and moves to describing the research process. It ends with a reflective account exploring the experience of conducting the interviews.

## **4.2. Research Questions**

This study seeks to explore the following overall research questions:

- What are the experiences of people with mental illness accessing health-related income benefits and which elements are helpful or problematic?
- Do individuals with mental illness experience particular types of self-stigma in relation to being in receipt of health-related income benefits?



### **4.3. Study Design**

This section of the chapter reports on the research process for the study, which took place between October 2016 and April 2017. It covers details of recruitment, sampling and the interviews alongside reflections on the effectiveness and limitations of different parts of this process.

The research consisted of primarily unstructured interviews with individuals who at the time of the study were currently experiencing a mental illness and in receipt of health-related income benefits, defined here as Jobseekers Allowance, Employment Support Allowance, Disability Living Allowance or Personal Independence Payments. These types of payments in particular were selected because they involve an eligibility assessment process based on specifically on health needs and each benefit forms a significant part of individual income for those who are in receipt of them. The topic areas included: experiences of accessing benefits, self and public perceptions of being unable to work/claiming social security payments due to mental ill health, stigma and social inclusion. The topic guide is available in Appendix 1. Unstructured interviews were selected in order to ensure participants were able to lead the direction of the study and as a relatively understudied area in the context of welfare reform research, to allow themes to emerge and be explored.

#### **Location**

The study took place in various locations across Leeds, a large city in the North of England. Leeds has a population of around 774,060 people (Leeds Observatory, 2015) and 11.7% of the working age population are claiming out of work benefits (Nov 2013, Leeds Observatory). The prevalence of mental illness in Leeds reflects that of the national population (Eaton et al., 2011).

This location was selected primarily for practical purposes. As a potentially hard to reach population, it was felt that it would be beneficial to conduct the research in a large city, therefore widening the pool of potential participants.

## **Timeline**

October to December 2016: Application for ethical approval and organisation level recruitment.

January 2017: Study information disseminated to organisation staff and potential participants identified.

January to April 2017: Participant recruitment.

February to April 2017: Interviews.

April to June 2017: Transcription and analysis.

## **Ethics**

Ethical approval for the study was granted by the Department of Health Sciences Research Governance Committee at the University of York on 28<sup>th</sup> November 2016.

## **Resources and Materials**

Materials: Printing of participant information sheets, recruitment posters, consent forms, incentive payment forms. The participant information sheet is available in Appendix 2. Materials were designed with a Flesch Kincaid readability score of secondary school level (score: 8.1) to maintain accessibility for potential participants.

Costs: Incentive payments financed using ESRC Research Training and Support Grant attached to PhD funding provided at £10 per interview to a total cost of £180. Travel expenses were offered to all participants but none were required. A mobile phone was purchased for contacting organisation staff and participants at a cost of £10 (approx.).

## **Recruitment**

Individuals were recruited through organisations offering support to people with mental illnesses living in the community. Potential participants were identified in conjunction with organisation staff from existing caseloads. Service users were approached by their key worker in the first instance and information about the study

provided. Where the person expressed an interest in participating, written information was provided followed by contact with the researcher after forty-eight hours, to enable the person to fully consider their involvement in the study and ask any questions. If the person agreed to participate at this stage, interviews were arranged either at organisational premises or at the home address of the person.

Social support organisations were targeted for access to participants for the study. This was felt to be preferential to recruiting from a clinical population because social support organisations offer access to a wider range of participants. As only a comparatively small number of individuals receive formal support for their mental health difficulties through psychiatric services, a clinical population could be limited to those with more severe mental health conditions, therefore not providing enough variation in the sample and missing those individuals whose illness is managed through primary care or who are not currently involved with healthcare services.

### **Organisation Level**

Access to participants was achieved in the first instance by targeting organisations with a remit of offering support around social circumstances to people with mental health difficulties. This criterion was used because by the nature of this type of organisation, it was likely that service users accessing this type of support would have the following characteristics: living in the community, experiencing a period of relative stability in their mental health therefore ensuring full capacity to participate and accessing the welfare system in some form.

In the first instance, contact was made with Community Links, an organisation offering housing, financial and social support across Leeds. This organisation in particular was selected because at the time of recruitment, they were acting a hub service for the city with direct access to a number of other organisations through their network.

Following initial contact with a service manager, it was agreed that I would attend a multi-organisation service manager meeting to discuss the study in November 2016 at which five services were represented: Community Links, Leeds Irish Health and Homes, Touchstone, St Anne's Community Service and Leeds Mind. All service managers agreed to participate in the research, pending ethical approval.

Ethical approval was granted on 28<sup>th</sup> November 2016 and the organisations were re-contacted at this point with a request to attend staff meetings to discuss the research and begin the recruitment process.

Two organisations did not respond to further contact following initial agreement at the service manager meeting. St Anne's had a change of service manager which appeared to disrupt contact and for Touchstone; no response was received so reasons are unknown. Three agreed to attendance at a staff meeting, all of which were arranged for January 2017.

Participant information sheets and posters were distributed at staff meetings. It was collaboratively agreed that individual staff members would discuss the study with service users on their caseloads in the first instance and then subsequently make contact with the service manager or the researcher directly to provide details of any interested parties. There was also an offer by two organisations to attend one of their regular support groups to speak to service users directly about the research.

Figure 4 outlines the routes to recruitment from initial contact through to the numbers in the final sample sourced from each organisation. Participant recruitment took place between January and April 2017.

Of the three organisations who continued through to the participant recruitment stage, the largest numbers in the sample were sourced from individual staff caseloads at Community Links. Both Leeds Mind and Leeds Irish Health and Homes suggested attending support groups for direct recruitment and the remaining four participants were sourced in this way from a Leeds Irish Health and Homes luncheon club. As no participants had been sourced through Leeds Mind by March 2017, alternative strategies for recruitment were discussed with the service manager. It was agreed that several group conveners would be contacted by the manager to explore the possibility of attending to discuss the research. One convener of a financial hardship group did make contact; however, there were difficulties with attracting numbers to the group itself and therefore this was postponed until the end of April 2017, at which point theoretical saturation had been reached from the existing interviews.

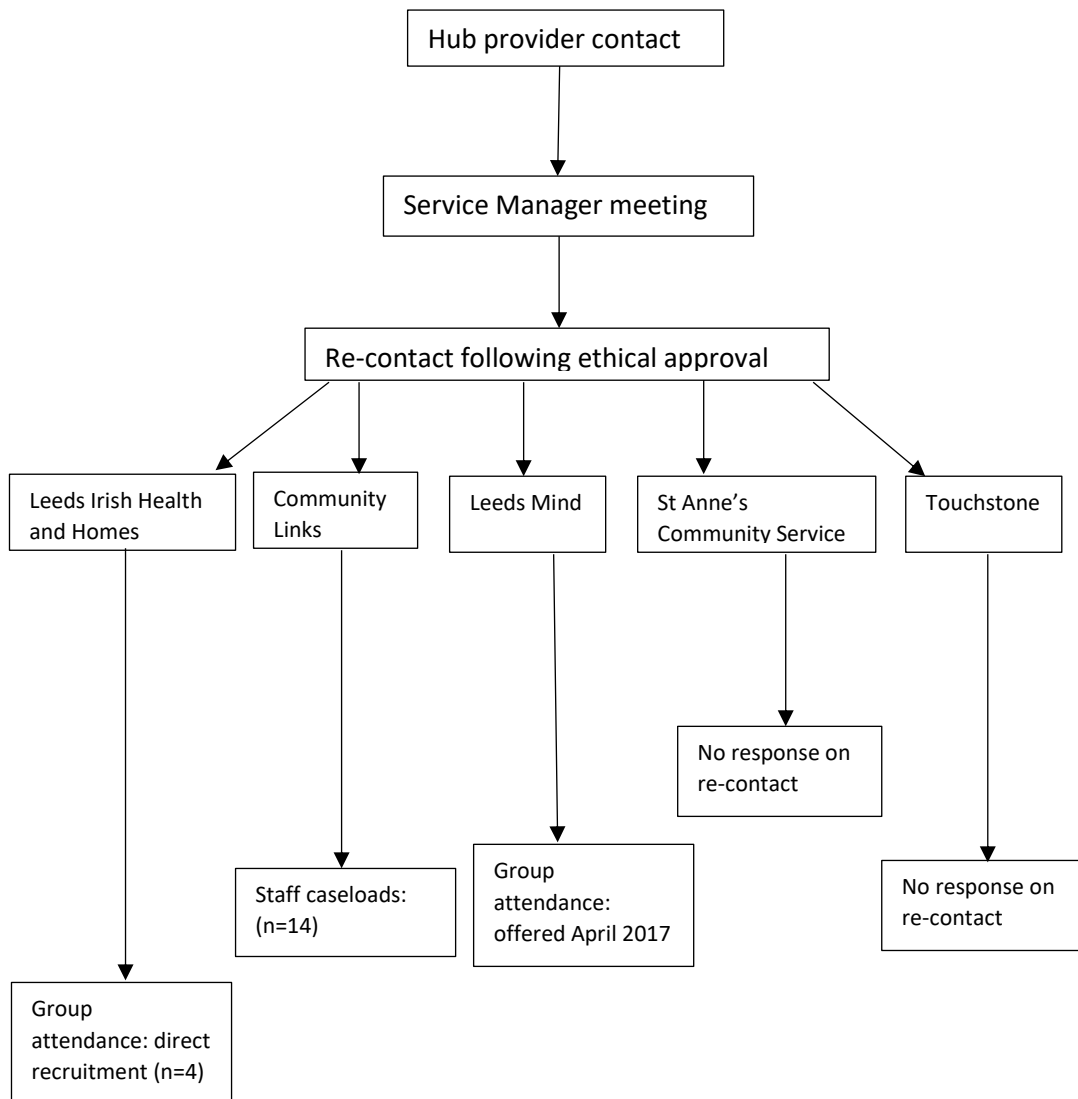


Figure 4. Organisation level recruitment

There are several possible reasons as to why success was variable across the organisations. Most notably, Community Links is a significantly larger organisation than either Leeds Mind or Leeds Irish Health and Homes. This meant a larger service user base therefore increasing the number of potential participants and numbers of staff to disseminate information and engage with service users about the study. Although staff members mainly appeared positive about the research, several staff members and service users during the recruitment period stated that their previous experience of research made them reticent to become involved on the basis that this

did not usually produce any meaningful outcomes or changes, therefore this was a potential barrier.

### **Participant Level Recruitment**

Eighteen participants took part in the study and were recruited through a combination of different routes between January and April 2017.

| <b>Recruitment Route</b>               | <b><i>N</i></b> |
|--|-----------------|
| Staff member contact                   | 13              |
| Word of mouth                          | 1               |
| Direct Recruitment (group attendances) | 4               |

Table 1. Routes of recruitment

### **Staff members**

Participants recruited via this route became involved in the study through a discussion with their key worker about the research. Following an initial expression of interest, staff members provided a participant information sheet, of which copies had been distributed during initial staff meetings and then provided the researcher with contact details to arrange an interview. In this case, participants were informed that they would be contacted forty-eight hours after receiving the information to ensure they had time to fully consider their participation in accordance with ethical guidelines. Where staff did not have access to information sheets, a copy was sent out to the participant by post and they were contacted by the researcher forty-eight hours after the arrival of the letter. In three cases for interviews that had been arranged through this route, participants reported that they would like to have their support worker present during the interview and this was accommodated.

### **Word of Mouth**

One participant expressed an interest to her key worker about participating in the research after her partner had completed an interview. Contact details were provided by the key worker and the participant was sent an information sheet by post with follow up telephone contact after forty-eight hours.

## **Direct Recruitment**

Four participants were recruited by the researcher directly following two attendances at the community lunch group. On each occasion, I gave a short introduction about the research to the group alongside providing flyers and information sheets. I then assisted staff to serve food and subsequently ate lunch with group attendees. Participation in this way offered an excellent opportunity to discuss the research on a more informal basis and for individuals to ask any questions.

I informed staff of any group members who expressed an interest in participating and contact details were obtained either from the person directly or with consent, from staff. Participants were provided with an information sheet during the lunch group and then given forty-eight hours to consider their involvement before further contact was made to discuss any questions or concerns and arrange an interview.

## **Attrition**

Two individuals who had initially expressed interest in the study did not subsequently participate. One individual experienced a bereavement in between initial contact and the interview itself and after rescheduling on one occasion, eventually felt that he could not commit to taking part. The second individual agreed to an interview but did not attend or respond to further contact; therefore the reason for attrition is unclear in this case.

All other individuals who initially expressed an interest in participating were recruited through to interview stage. Staff members were key to ensuring the success of the recruitment process by generating interest in the study with service users, facilitating access to the lunch group setting and supporting the practical arrangements to enable the interviews to proceed. Individuals generally expressed a keen desire to put forward their opinions and experiences on the topic areas and appeared interested in the idea of being part of a research project. Although experiences of the welfare system were both positive and negative, most participants expressed that by taking part in an interview, they aimed to educate others about the lived experience of mental illness.

## **Interview setting**

Following the forty-eight hour period, participants were contacted again to discuss any questions about the research and whether they wished to proceed. No individuals declined to participate at this stage.

Interviews were arranged at organisational premises or the home address of the participant. This was dependent on two main factors, the most convenient location for the person and the background information available about the individual to the organisation or staff members. In several instances, staff members recommended not attending the home address of the participant due to known risk factors and therefore interviews were arranged at organisation premises. Where little or no information was available, for example, those who were group attenders but without an individual key worker, interviews took place at organisation premises. All rooms at organisational premises were private offices or spaces, booked in advance by the researcher or a staff member.

On one occasion, arrangements had been made by a support worker to meet initially at a coffee shop in a location convenient to the participant and then to visit a local library with rooms available but on arrival the participant expressed that he was very open about his mental health and would speak about the topic areas in the coffee shop, so this was facilitated. In this instance, extensive field notes were taken in anticipation of background noise on the audio recording, but this was not negatively affected and a relatively private space was secured. Another interview took place in a general hospital setting where the participant was a long-term patient due to physical health issues and in this instance, the ward manager provided her office space for the purposes of the research.

The type of setting does not appear to have impacted on interview duration or the topic areas discussed. Home visits did provide a valuable source of information in terms of the context in which participants lived. All participants in the study for whom these details were known lived in socioeconomically deprived areas of the city that were either one or two bus journeys away from the city centre.



## **Sampling**

The study aimed to recruit twenty participants in the first instance through organisations who specialised in providing social and practical support to individuals with a mental health issue living in the community. This sample size was selected to ensure that a broad range of respondents could be interviewed whilst recognising that the population may be difficult to reach.

The inclusion criteria were: adults (defined as working age: 18-65) with a mental health difficulty, living independently and in receipt of health-related income benefits.

A convenience sampling method was employed in the first instance based on those service users who expressed an interest in taking part in the study. Following this, a purposive approach was employed to achieve greater balance in the sample in relation to mental illness (between serious and common mental disorders) and gender since these characteristics could impact on individual experiences.

The sample used in this study was primarily convenience based due to a reliance on staff members to source participants from their current caseloads. It is possible that the individuals recruited to the sample might be different to those who declined to participate. Prior to recruitment the researcher clarified to staff that the study sought to explore all types of experiences of the welfare system, in an attempt to mediate the possibility of staff seeking out particular participants with for example, unusually negative experiences. The exploratory nature of the study was also emphasised to participants prior to completing the interview and the findings do include a spectrum of different experiences.

Although there was the potential to recruit to the initial target of twenty participants, as no new themes appeared to be emerging from around the fourteenth interview, recruitment continued only to achieve an adequate distribution of demographic characteristics, therefore the final sample included 18 participants. The final sample consisted of ten males and eight females, with an age range of 25 to 60 experiencing illnesses across the spectrum of common and severe mental illness.

## **Mental Health**

The mental health issues described in the sample were self-reported, however participants typically stated that they had been provided with their diagnosis by a healthcare professional such as a General Practitioner or psychiatrist. One participant was unable to provide a clinically recognisable diagnosis but stated that a healthcare professional had described her symptoms as ‘emotional difficulties with self-harm’. One participant, whilst acknowledging he did experience difficulties with his mental health, declined to give information about specific symptoms or a diagnosis during the interview. A further participant stated that whilst she perceived her main issues to be anxiety and depression, she felt that healthcare professionals conceptualised her problems differently although did not provide information as to her given diagnosis.

The sample had a high level of co-morbidity with participants generally reporting more than one mental health diagnosis or difficulty. The most commonly reported problems included depression, anxiety and substance use however the sample also included a number of individuals with serious mental illness, many of whom reported co-occurring anxiety or depression. Table 2 provides count data for the mental health issues in the sample and Table 3 provides information by individual participant, using pseudonyms.

## **Self-Report Measures**

Using self-report measures has the potential to be problematic since the information provided is not necessarily objective or verifiable in the same way as for instance, a clinical record. However, the primary criterion for accessing support through one of the involved organisations is having a current mental health issue, which provides a certain level of verification.

Further to this, in a study of these topics, the way an individual perceives their problems is valuable, since how the person views their own difficulties is integral to experiences of stigma and this was reflected in accounts of how symptoms affected aspects of daily life. In addition to this, interviewees had attempted to obtain financial support based on an application completed using primarily their own definition of their health problems, albeit that some participants had outside support. Some of the participants reported that they were in contact with community mental health services and of having had a previous psychiatric hospital admission.

Table 2 indicates that depression was by far the most commonly reported difficulty, followed by anxiety. All other illnesses are found less frequently in the general population and it would therefore be expected that these would also occur less often here. Nevertheless, the sample does capture the experiences of individuals with a wide range of different mental health difficulties. Table 3 provides detailed information about mental health issues for each individual in the sample. This indicates that fourteen participants in total described some kind of co-morbidity with a relatively even distribution of anxiety and depression across gender in the sample.

| <b>Mental Health Condition</b>           | <b>Participants (N)</b> |
|--|-------------------------|
| Depression                               | 12                      |
| Anxiety                                  | 6                       |
| Psychosis                                | 3                       |
| Substance Misuse                         | 3                       |
| Bi-Polar Affective Disorder              | 1                       |
| Borderline Personality Disorder          | 1                       |
| Post-Traumatic Stress Disorder           | 1                       |
| Attention Deficit Hyperactivity Disorder | 1                       |
| Learning Difficulties                    | 1                       |
| Learning Disabilities                    | 1                       |
| Emotional Difficulties and Self Harm     | 1                       |
| Not Disclosed                            | 1                       |

Table 2. Count data for self-reported mental health condition

| <b>Pseudonym</b> | <b>Gender</b> | <b>Self-reported mental health condition/s</b>    |
|------------------|---------------|---|
| Margaret         | Female        | Depression  |
| Sarah            | Female        | Anxiety, depression                               |
| Clare            | Female        | Bi-polar affective disorder                       |
| Ruby             | Female        | Borderline personality disorder, substance misuse |
| Louise           | Female        | Psychosis, depression, learning disability        |
| Jane             | Female        | Anxiety, depression                               |
| Susan            | Female        | Anxiety, depression                               |
| Jenny            | Female        | Emotional difficulties with self-harm             |
| Robert           | Male          | Depression, learning difficulties                 |
| Joseph           | Male          | Post-traumatic stress disorder, depression        |
| David            | Male          | Depression, anxiety, psychosis                    |
| Callum           | Male          | Depression, substance misuse                      |
| Peter            | Male          | Depression, substance misuse                      |
| Stephen          | Male          | Anxiety, depression                               |
| Mark             | Male          | Psychosis   |
| Anthony          | Male          | Attention deficit hyperactivity disorder, anxiety |
| Alan             | Male          | Depression  |
| Thomas           | Male          | Unknown   |

Table 3. Participant characteristics

## **Interviews**

Interviews took place at a combination of organisation premises (n=8) and where enough information was known about the person, at home addresses (n=8). One interview also took place in a general hospital setting and another in a coffee shop. A support worker was present at three of the interviews. Support workers were asked not to participate in the interview discussion and only to intervene if the person was felt to require emotional support or if they felt that the interview should be stopped. In two cases the support worker remained silent throughout the duration of the interview, in the third; the support worker interjected on several occasions to offer clarification about appointment dates or times but did not otherwise contribute to the interview content. It is not possible to ascertain how the presence of a support worker may have impacted on responses without also conducting interviews with the same person without a support worker present; however, there was no difference in interview duration. The initial aim was to complete interviews lasting around one hour and the final mean duration for the sample was 57 minutes with a range of 25 to 85 minutes. The duration of interviews reduced slightly as the research progressed, due in part to variation amongst individual participants but also due to researcher experience (see reflective account).

Prior to the interviews taking place, consent forms were signed and payment provided. Several earlier participants commented after the interviews that they had expected a more structured format; therefore the decision was made to give a brief overview of the intended topic areas at the beginning of the interview, in addition to the information provided in the participant information sheet. I explained that the interview would cover experiences of accessing benefits, mental health and stigma and take the format of an informal conversation.

A common misconception was that the research was in some way being conducted on behalf of the Department of Work and Pensions. This was a concern since it had the potential to impact on what individuals were willing to disclose about their experiences and so the decision was taken to make it explicit that I was not associated with this organisation at the beginning of the interviews. Confidentiality and anonymity were also emphasised as part of the general pre-interview briefing, alongside a reminder of the right to withdraw from the interview at any time.

An iterative approach was used to refine the topic areas as the interviews progressed and certain areas became the focus of discussion. This was also reflected in the changing structure of the interviews. Whilst initial interviews remained relatively unstructured, a more defined approach to the questions ultimately meant that the interviews moved closer to a semi-structured approach during the research process. Transcripts were reviewed after the first three interviews and codes and thematic maps were discussed and refined at the data analysis stage during supervision and thesis advisory panel meetings.

### **Incentive payments**

A £10 incentive payment was provided to each participant in the study at a total cost of £180. The monetary value of the incentive was agreed with service providers prior to conducting the research because it is in line with the pre-established pay structure for service user participation in other organisational activities such as focus groups or service improvement initiatives that are around an hour in duration. Payment was provided at the beginning of interviews and participants were informed that they would retain the payment whether or not they decided to withdraw at any time. Participants who travelled to the interview came with relatives or used a disability bus pass and all other interviews took place at home addresses, therefore no participant travel costs were incurred.

### **Data management**

In accordance with ethical guidance, paper consent and payment forms were deposited in a locked drawer at the Research Centre for Social Sciences and a password protected, encrypted Dictaphone was used to complete audio recordings. Data files were uploaded to my personal University of York user account and accessed through a password protected computer.

Personal information disclosed during recordings was not included in the typed transcription to preserve anonymity and all participant names have been replaced with pseudonyms. As some of the services and facilities for individuals with mental health issues have a relatively small user base and particularly given that information about individual diagnosis is available, extra caution was exercised to ensure that other information with the potential to be personally identifiable was also redacted. This included organisation, worker and mental health service information, such as

hospital or day centre names, drug and alcohol services and small residential areas, for example, the names of particular housing estates. These were replaced in transcriptions with a generic descriptor to preserve the context of what the participant was discussing, as with the following extract from Anthony's transcription:

*"I haven't done owt for years now but this recently, this (**service offering arts and activities**) place that er, (**support worker**) was telling you about, that's like slowly getting me into the idea of being able to actually, maybe go back to, back to uni-, er college."*

### **Staff Study**

During a review of transcripts and emerging themes part way through the study, my supervisors and I thought that it may be beneficial to gain the perspective of organisation staff on some of the issues raised by interviewees, particularly as community-based keyworkers can often be involved in supporting service users to navigate the welfare system.

The possibility of recruiting staff for interviews was discussed and agreed at management level with Community Links and Leeds Irish Health and Home and following on from this; ethical approval was sought and provided by the Department of Health Sciences Research Governance Committee in March 2017. Having already built a rapport with a number of keyworkers through recruiting participants and attending the luncheon club, a simple recruitment process was anticipated.

Unfortunately, however, a change of tender in services across Leeds meant that in April 2017, all staff transferred to a new provider or left their organisation. Not only did this cause difficulty with contacting individuals, it also meant that staff had very limited time during the busy changeover period. Several attempts to engage with staff members were made but without success and no participants were recruited to the study. The key issue affecting recruitment here was the timing of the research.

#### **4.4. Data analysis**

Thematic analysis is a method of capturing the key topic areas emerging from a set of qualitative data by enabling commonalities to be established across multiple participants and perspectives. It is designed to provide a rigorous method of exploring qualitative data through the application of a structured approach to analysis (Braun and Clarke, 2006). There are a number of approaches to thematic analysis and for this particular research, I have chosen to use the six stage framework proposed by Braun and Clarke (2006). This was a pragmatic decision taken because the study is exploratory and this particular framework enables the researcher to define each stage of the analysis in a flexible way.

The next section of the chapter documents the process and my experiences of each phase of the six stage framework.

##### **Stage One: Familiarisation**

Familiarisation is the process by which the researcher undertakes an in-depth appraisal of the data set through repeated viewings of the material. This ensures the researcher has a good overview and understanding of the data before proceeding to detailed coding. All interviews were transcribed verbatim by the researcher and this manual listening to and recording of the data represents the first component of familiarisation since it offers the researcher the opportunity to become acquainted with the information whilst noting initial thoughts and ideas (Braun and Clarke, 2006).

Interviews were transcribed as they were completed during the data collection process which also offered opportunity to reflect on my interview technique and to review the style and content of questions. As data collection progressed, I was able to refine the topic guide and follow up on potentially interesting areas to explore further in later interviews, using an iterative approach. Within the framework proposed by Braun and Clarke, however, this is potentially problematic.

The familiarisation stage here assumes that all transcription takes place once data collection has been completed, therefore allowing an overview of the data as discussed. Familiarisation in this study was part of the analysis but also acted to influence the data itself because transcription informed and therefore altered future

interviews. There is no guidance on how to proceed in these circumstances within the framework, however, as an inexperienced researcher, I felt that working reflexively should be prioritised to maintain the pedagogic process and improve the integrity of the data.

Once all data had been fully transcribed, a further reading of all interview data collectively was undertaken in accordance with the usual familiarisation process. Possible areas of interest and broad ideas for themes were noted down at this point.

### **Stage Two: Initial Coding**

Line by line coding of the data was completed following familiarisation initially by hand in order to ensure a close reading of the transcripts. The transcripts were then uploaded and organised in Nvivo 11 (QSR International, 2015) which allowed the names of codes to be refined and an initial assessment of how the codes were distributed across the interviews. No codes were removed or aggregated during this phase since doing so could limit the later development of themes.

The research questions sought to explore the experiences of people with mental health issues in the context of the welfare system and because there was limited evidence available on this topic, the decision was taken to code all information in the interviews so that themes could emerge from the data rather than using a pre-specified coding frame. Coding inductively provided a safeguard against losing potentially important information during the transition from coding through to theme development. Earlier interviews were less structured and therefore covered a wider range of topic areas meaning that large quantities of codes were generated initially, becoming more manageable as I progressed through the data.

The close reading facilitated during line by line coding promotes rigour during subsequent theme development because it ensures that as much detail as possible is captured prior to moving on to this stage, however I found that during coding it was quite difficult to capture the complexity of individual circumstances. Coding short excerpts of data has the potential to inadvertently remove the underlying context from the spoken words which could be later compounded as these are collated into themes.



Braun and Clarke (2006) suggest that the researcher distinguish between semantic themes derived directly from the codes and latent themes which focus on underlying meanings, however, since this study considers both the process of accessing financial support and the implications for interviewees, I found that both were relevant. This does not fit perfectly with the thematic analysis framework but by using both types of themes, I felt I was able to more fully grasp the meanings behind the experiences and it does fit in well with a critical realist approach. A visit to the job centre, for example, may incorporate the availability of resources or the timing of appointments but could also be framed by underlying power differentials. This issue was addressed by categorising the same excerpts across multiple codes.

Stigma in the data was coded by using constructs informed by existing research or by the way in which this was discussed by participants. 'Stigma over time' was a code usually derived from direct questioning on any changes to stigma that the person may have noticed during the course of their illness and 'hierarchy of stigma' refers to expressions volunteered by participants in relation to perceived 'types' of welfare system user. Social stigma (also known as public stigma) is a concept which captures public attitudes towards mental illness whilst self-stigma refers to the internalisation of these negative attitudes by the stigmatised person (Thornicroft, 2006).

As the analysis progressed however, it became clear that self-stigma did not capture all elements of participant perceptions of stigma in this context. Although individuals experienced psychological effects of negative public attitudes, for example, lower self-esteem, which would be in keeping with self-stigma, they also sometimes rejected the views of others as unfair, which may suggest that internalisation was not taking place. In order to reflect this difference, 'felt stigma' was introduced as a code. This is a form of stigma, discussed recently by Baumberg (2016), which acknowledges that the person is affected by negative public attitudes but does not necessarily internalise these beliefs. 'Interpersonal stigma' refers to direct experiences of stigma during personal interactions and was introduced as a code to differentiate between more abstract perspectives on the way the public may view mental illness in this context (social stigma) and experiences of stigma at the individual level.

The initial codes generated from the data are available in Table 4, the number of references by participant and by total frequency across the sample are included in Appendix 3.

| <b>Code name</b>   | <b>References by participants (n)</b> | <b>Total frequency of references</b> | <b>Code name</b>                       | <b>References by participants (n)</b> | <b>Total frequency of references</b> |
|--|---------------------------------------|--------------------------------------|--|---------------------------------------|--------------------------------------|
| Age  | 3                                     | 6                                    | Invisibility                           | 10                                    | 31                                   |
| Appeals  | 6                                     | 17                                   | Job centre                             | 9                                     | 43                                   |
| Bureaucratic structures                                    | 14                                    | 43                                   | Job Seekers Allowance                  | 5                                     | 9                                    |
| Celebrities and mental health                              | 5                                     | 6                                    | Justifying claim                       | 12                                    | 36                                   |
| Citizenship and rights                                     | 4                                     | 12                                   | Benefits in the media                  | 4                                     | 14                                   |
| Claims process   | 15                                    | 49                                   | Media and mental health                | 12                                    | 21                                   |
| Community  | 9                                     | 21                                   | Mental health services                 | 17                                    | 85                                   |
| Conditionality   | 10                                    | 38                                   | Mental health symptoms                 | 18                                    | 108                                  |
| Debt   | 9                                     | 14                                   | Playing the system/fraud               | 12                                    | 38                                   |
| Deservingness  | 8                                     | 10                                   | Political context                      | 14                                    | 42                                   |
| Disability Bus pass  | 4                                     | 4                                    | Power                                  | 16                                    | 44                                   |
| Disability Living Allowance/Personal Independence Payments | 7                                     | 18                                   | Previous employment                    | 9                                     | 14                                   |
| Domestic Abuse   | 2                                     | 2                                    | Recovery                               | 13                                    | 36                                   |
| Drugs and alcohol  | 10                                    | 32                                   | Responsible citizens                   | 6                                     | 17                                   |
| Employment Support Allowance                               | 13                                    | 33                                   | Self-esteem                            | 6                                     | 8                                    |
| Exploitation   | 5                                     | 9                                    | Self-stigma                            | 8                                     | 13                                   |
| Family and friends   | 16                                    | 68                                   | Social inclusion                       | 14                                    | 50                                   |
| Felt Stigma  | 12                                    | 38                                   | Social stigma                          | 18                                    | 86                                   |
| Financial pressures  | 13                                    | 47                                   | Stigma over time                       | 6                                     | 7                                    |
| Finding employment   | 10                                    | 36                                   | Suicidality                            | 6                                     | 11                                   |
| 'Genuine' claimants  | 13                                    | 39                                   | Surveillance                           | 8                                     | 18                                   |
| Hierarchy of stigma  | 10                                    | 20                                   | Feeling misunderstood                  | 10                                    | 20                                   |
| Housing  | 10                                    | 27                                   | Universal Credit                       | 1                                     | 3                                    |
| Identity   | 3                                     | 5                                    | Validity of claim                      | 15                                    | 82                                   |
| Implicit blame   | 13                                    | 35                                   | Wider unemployment/economic conditions | 5                                     | 9                                    |
| Income   | 13                                    | 22                                   | Work and mental health                 | 15                                    | 37                                   |
| Intentional targeting/discrimination                       | 5                                     | 10                                   | Work Capability Assessment             | 16                                    | 44                                   |
| Interpersonal stigma                                       | 14                                    | 37                                   | Inherent worklessness                  | 4                                     | 5                                    |

Table 4. Initial codes

### **Stage Three: Searching for themes**

Once the information associated with each code was collated in Nvivo, all excerpts were checked to ensure accurate representation of meaning and fidelity with the code itself. At this stage, some excerpts were reassigned to new or existing codes, for example, 'Disability Bus Pass' was subsumed into 'DLA/PIP' since the number of excerpts was relatively minimal (4) and a review of these suggested that they may not contribute to the analysis as a standalone code.

In relation to this stage of the analysis, I found the guidance provided by the framework to be somewhat ambiguous because there is not a clearly defined method of generating themes. Braun and Clarke (2006) suggest that themes can be generated based on ideas that are most frequently mentioned or are discussed by the most number of participants or which seem important, regardless of how often they appear in the data set. Consequently, despite the rigor attached to the coding process, finding themes within the data is a highly subjective process because it is based on researcher perceptions as to the salient aspects of the data, rather than necessarily what is most prevalent or objectively determined. To some extent, this criticism may be applied to qualitative research more broadly and this is why researcher reflexivity is key. Developing themes in this way could also lead to the voices of some participants being given higher priority than others. Where possible, quotes that expressed contradicting views on a topic here were kept within the same code so that the range of participant experiences could be considered.

### **Stages Four and Five: Reviewing and Defining Themes**

In writing up this analysis, I have integrated stages four and five because the reviewing and defining of themes took place as part of the same process.

A large number of themes emerged from the data in the study and the final themes presented here were ultimately selected based on their relevance to the research questions. Other themes served to provide context in the final stage of the analysis, writing the report. This included for example, mental health service use and community inclusion. Although not directly addressing the particular research questions in this study, they are important to the lived experiences of participants.

Braun and Clarke (2006) suggest when codes are converted into themes, they should ideally move beyond the direct questions asked within the interview study and towards an assessment of underlying meaning. Whilst underlying meaning is a key part of interpreting this type of data, from a pragmatic perspective for this study, the process of claiming benefits is a key element of the research questions; therefore some of the themes here are associated with direct questions, for example, the process of attending a Work Capability Assessment.

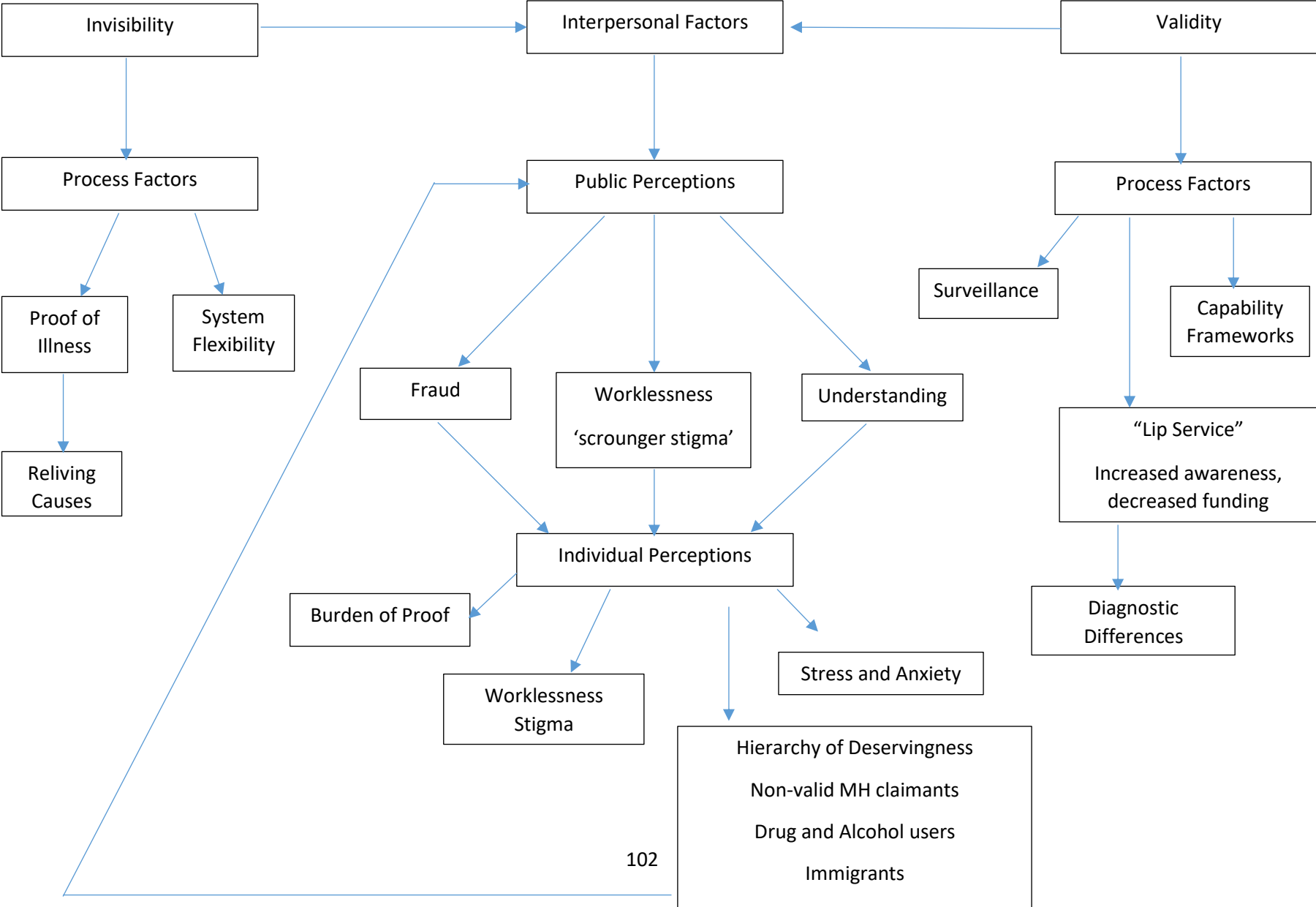
An initial thematic map was produced in order to explore the associations between different themes in the data, visible in Figure 5.

### **Stage Six: Producing the final report**

Writing up the analysis provides further opportunity for reflecting on and defining themes (Braun and Clarke, 2006). In Chapter 7, the findings are organised according to themes associated with each of the two research questions. The first part explores themes related to lived experiences of the process of claiming benefits for individuals in the sample, whilst the second focuses on stigma and associated narratives found within the data.

Alongside defining themes and considering how these relate to existing literature and concepts, producing the final report includes the selection of quotes to illustrate each of the themes, therefore giving expression to individual experiences and ensuring these feature prominently in the research findings. As in the initial development of themes, caution should be exercised to ensure that certain participant voices do not become more dominant than others. In order to assist with choosing quotes and to ensure a fair distribution across participants, a table incorporating the number of codes assigned to each interview and the total number of excerpts coded for each person was created for reference purposes (see Appendix 3). Although to some extent, quotes used may vary depending on which of the participants has discussed a particular theme, this was a useful exercise because it enabled me to keep in mind the individuals who might otherwise be less likely to be included.

Figure 5. Initial thematic map



## **4.5. Reflective Account**

This section of the thesis describes several challenges relating to the researcher experience during the course of the study that have not otherwise been covered during the preceding discussion.

### **Objectivity**

I began the research process with pre-existing ideas about the experiences of people with mental illness accessing social security, informed by the media, prior reading and my previous role as a community mental health nurse, during which I had supported service users through this process. Primarily these experiences and perceptions were negative. Whilst my existing knowledge of this subject area was useful in designing the study and formulating research questions, as a researcher I was very conscious of this viewpoint going into fieldwork.

I was keen to maintain a fair and balanced approach to ensure that whatever my own opinions, participants were able to recount their experiences without undue influence. This was key to addressing the research questions effectively and determining what was helpful as well as problematic about the process. Whilst it is important to be aware of these personal perspectives when conducting qualitative research, I believe this also affected my ability initially to engage in effective discussion with participants. Alongside feeling apprehensive about conducting my first piece of qualitative research, this self-consciousness had a limiting effect.

During initial interviews, I monitored my body language, intonation and questioning style in a perceived attempt not to impose my own views on participants, however, this served to hinder the development of effective rapport. I felt unable to ask follow up questions when participants reported experiencing difficulties in a particular area or to ask spontaneous questions away from those included in the topic guide. I was also conscious here of the trust placed in me by the organisation staff and the participant and so did not wish to appear intrusive.

There were several consequences to this approach. Firstly, it led to some relatively stilted discussions as I struggled to move away from my 'script'. Where participants answered questions in a way I had not anticipated, I lacked the spontaneity to know

how to take the interview forward. Secondly, I remained quite passive during the discussion because I equated this with objectivity. This is very evident in earlier interviews, which are characterised by lengthy sections of discussion and description that are not relevant to the topic areas.

During a review of the first three interviews in supervision which served as a pilot for the topic guide, we discussed these concerns and following this, I began to take a more active approach to the interviews and to ask follow up questions. This remains an ongoing learning process, particularly knowing when to take a more active role during interviews and when to stay passive so that participants can recount their experiences fully. I believe, however, there was a notable improvement in the conciseness of the interviews over time and with increasing confidence, I was able to approach the topic areas with greater skill and effectiveness.

### **When the Interview Ends**

Many of the interviewees in this study recounted difficult life circumstances during discussion, including traumatic historical events and current hardships such as isolation, financial difficulties and stigma. These were difficult to hear and sometimes to respond to in an interview context.

After the interview had finished on several occasions, participants requested advice or support. Robert explained following the interview that he was uncomfortable discussing his mental health issues in detail on the audio recording device but did subsequently recount several traumatic life events including bereavements, becoming quite distressed in the process. Here I gained the permission of Robert to discuss what he had told me with his key worker with the aim of arranging support such as counselling. The key worker later fed back that this had been arranged. Several participants asked for support with their benefits after raising issues during the interviews. Where possible, I made suggestions of relevant agencies to contact but usually signposted to key workers.

Jane became distressed during her interview when discussing the hardship of managing on a low income. The interview was stopped at this point with the offer to discontinue, however she stated that she would like to proceed and finish. Her support worker, whom she had worked with for some time was present throughout and offered practical as well as emotional support with these issues.



In the clinical context, when hearing about problematic situations such as these, there is the opportunity to provide longer term, proactive solutions and to build up a relationship with an individual to address these issues. In the short amount of time taken to complete the interview process, it is not possible to facilitate this type of support. It was therefore difficult at times to know the boundaries of advice and involvement, given my role as a student researcher in this context. I made use of supervision to discuss these issues alongside completing a reflective field diary throughout the process.

Overall, I feel that I have learnt a significant amount from completing this research study. The practical application of learning that I have completed previously in relation to qualitative research design has been especially useful, particularly in relation to managing the issues that may arise in real world research settings as compared to the theoretical context. This includes not only my role as a researcher but also the practical management of aspects such as creating interest in the study, gaining staff support, participant recruitment and the interview process itself. Communication with those involved in the study in all aspects of the process is key and was a central part of ensuring that the research was able to progress. The study is limited in terms of methodology by the fact that all interviews took place in the same city, therefore although participants were accessing different welfare services depending on which area they lived in, it is possible that some of the effects are due to the way services are designed in this particular context. The implications of this and other aspects of the study are discussed further in Chapter 7.

# **Chapter 5: Administrative data analysis**

## 5.1. Introduction

The plan for this analysis was generated to further explore findings from the interview study, in which there was a clear and frequently articulated perception amongst interviewees that they felt disadvantaged by mental illness being poorly understood in the welfare system, leading to difficulties with eligibility assessments and a greater risk of experiencing some of the effects of conditionality such as benefit sanctions. Similar perceptions have emerged from other recent welfare reform studies in which individuals with mental illness form part of the sample (Garthwaite, 2011; Dwyer et al., 2016; Patrick, 2017). The potential consequence here is that people with mental illnesses may receive lower levels of financial support than they are entitled to and require in order to mitigate against socioeconomic deprivation.

Despite increasing concerns about a lack of understanding about mental illnesses in this context, there has not to date been any statistical analysis of claimant data to investigate these issues further. Whilst lived experiences are of great importance and relevance, analysis of administrative data on claimants could be a useful and informative addition to the current evidence base.

Recent data releases from the Department of Work and Pensions (DWP) may present opportunities to investigate these issues further. Using data for claimants being reassessed from their existing Disability Living Allowance (DLA) entitlement to the new extra-costs benefit – Personal Independence Payments (PIP), it is possible to explore two key findings from the existing qualitative research a) whether individuals with a mental illness are financially disadvantaged following this particular welfare reform and b) whether new eligibility assessments are problematic for people with a mental illness. By using claimants with other health conditions as a comparator, it may be possible to ascertain how outcomes for people with mental illness compare to people with other health conditions following extra-cost disability benefit reform.

## **5.2. Hypotheses**

The hypotheses for this study are as follows:

### **Hypothesis A**

H<sub>0</sub>: There is no difference in financial disadvantage following reassessment for Personal Independence Payments for claimants with a mental illness compared to those with other health conditions.

H<sub>1</sub>: There is a financial disadvantage following reassessment for Personal Independence Payments for claimants with a mental illness compared to those with other health conditions.

### **Hypothesis B**

H<sub>0</sub>: There is no difference in the number of individuals with a mental illness who have their claim for Personal Independence Payments disallowed following an eligibility assessment compared to those with other health conditions.

H<sub>1</sub>: There is a difference in the number of individuals with a mental illness who have their claim for Personal Independence Payments disallowed following an eligibility assessment compared to those with other health conditions.

## **5.3. Plan of Analysis**

In 2012, it was announced that all existing claimants in receipt of Disability Living Allowance (DLA) would undergo a reassessment process in order to transfer over to the reformed version of this benefit, known as Personal Independence Payments (PIP). In the wider academic and media context, concerns have been raised as to the suitability of new eligibility assessment criteria for mental health conditions (Callanan, 2011; Abdul-Hamid and Bhui, 2014). The key changes to eligibility assessments for PIP compared to DLA for most claimants include a longer qualifying period, mandatory periodic claim reviews and additional requirements to attend a face to face medical assessment (Kennedy, 2011). The updated functional assessment also takes account of aids and adaptations when considering how a person is affected by their health condition (Department for Work and Pensions, 2011). Financial support is awarded based on a person needing help for more than half of the time in two main areas: daily living, for example, washing and dressing; and mobility (Department for Work and Pensions, 2016). Both components can be awarded at a standard or enhanced rate depending on how severely the person is assessed as being affected by their health condition (Gov.uk, 2018). Once a paper

application has been completed, claimants are invited to an eligibility assessment conducted by contractors, e.g., Capita, ATOS and information is then passed to a DWP ‘decision maker’ who decides on the final award.

Coinciding with the migration of claimants to the new benefit, the DWP released statistics associated with the transfer of claimants from DLA to PIP and a broad range of other benefits available in the welfare system. In December 2016, data on all claimants reassessed between 8<sup>th</sup> April 2013 and 31<sup>st</sup> October 2016 was made available for public use, derived from information collected through DWP administrative systems which adhere to standards and quality checks set by the UK Statistics Authority.

Reassessment data is useful for exploring the impact of reforms because it assumes an existing level of need, given that the person is already in receipt of benefits associated with their health condition (DLA) at the time they undergo reassessment. Although it is not possible to determine baseline eligibility without knowing the health background of individual claimants (for example, it may be that the correct decision is to deny the person the benefit following reassessment), it is feasible to undertake a comparative analysis to test how this process affects certain groups of claimants compared to others.

At the time of the first statistical release in December 2016, the charity Mind issued a brief statement outlining the proportions of claimants with a mental illness who had experienced a reduction to their benefits as a result of reassessment (Mind, 2016); however, no statistical analysis has been completed to further explore this data set.

Hypotheses will be tested via a comparative analysis to ascertain whether claimants with a mental illness experience an overall financial disadvantage and worse eligibility assessment outcomes relative to claimants with other health conditions following their reassessment from DLA to PIP. The term ‘disadvantage’ has been used here to define individuals who receive less financial entitlement following reassessment from DLA to PIP because their benefits have either been reduced or stopped. It should be noted here that some claimants with mental health conditions have seen their payments increase since transferring from DLA to PIP.

## 5.4. The Dataset

The data used in this analysis covers all claimants aged between 16 and 64 who were reassessed for transfer from DLA to PIP between 8<sup>th</sup> April 2013 and 31<sup>st</sup> October 2016. Data was accessed and downloaded on 22<sup>nd</sup> September 2017 and this represents the most recent data release at this time. The dataset is comprised of summary information which includes the total count of individuals reassessed during the time period and the percentage of claimants who experienced a particular outcome following reassessment, categorised by main health condition. The possible outcomes of a reassessment are defined in the following categories (wording from dataset notes):

**Award Increased:** The Department have made a decision to award PIP and the total monetary value of the PIP award (Daily Living plus Mobility component) is higher than the total monetary value of the DLA award (Care component plus Mobility component).

**Award Unchanged:** The Department have made a decision to award PIP and the total monetary value of the PIP award is the same as the total monetary value of the DLA award.

**Award Decreased:** The Department have made a decision to award PIP and the total monetary value of the PIP award is less than the total monetary value of the DLA award.

**Disallowed post-referral to the assessment providers (AP):** Claims that have been disallowed following the assessment due to the claimant not scoring enough points at the assessment to be awarded the benefit or the claimant failing to attend the assessment without good reason.

**Disallowed pre-referral to the assessment providers (AP):** Claims that have been disallowed due to failure of basic eligibility criteria or non-return of the Part 2 form within the time limit and have not been marked as requiring additional support.

**Withdrawn:** All claims that have been withdrawn by the claimant prior to a decision being made. This can take place at any point in the claimant journey following registration of a claim.

To create a dataset for use in this analysis, the percentage of claimants experiencing each of the six reassessment outcomes were converted back to count data using the overall reassessment totals for each health condition.

### **Main Disabling Condition**

Individuals are split into 54 categories in the data set according to their main health condition which is also the primary reason for their existing DLA claim. Some of the terms used to describe health conditions in the sample are relatively outdated and may be altered under the new PIP framework. Anxiety and mood disorders, for example, are categorised here as “Psychoneurosis”. Rarer illnesses for example, haemophilia include a very small number of claimants (200 out of 526,000), and some illness categories include missing data on the total number of individuals reassessed.

As the focus of the analysis is on individuals with a mental illness and claimants with other health conditions are included as a comparator only, the decision was made to remove all conditions where the total number of claimants was under 1,000 or where data was missing. A review of the categories with missing data suggests that these are conditions which would be unlikely to include a large number of claimants and therefore affect the outcome of the analysis, for example, malaria or total parenteral nutrition (conditions requiring intravenous feeding). There was no missing data for any mental health condition included in the analysis.

Following the removal of this data, the total sample for the analysis included 513,700 claimants with 38 different health conditions; see Table 5 for further details. This data was uploaded into Stata version 15.1 for analysis (Statacorp, 2017).

| Main Disabling Condition                          | Total number of Claimants | Main Disabling Condition         | Total Number of Claimants |
|---|---------------------------|----------------------------------|---------------------------|
| AIDS  | 1,000                     | Learning Difficulties            | 42,900                    |
| Alcohol and Drug Misuse                           | 5,200                     | Major Trauma                     | 3,800                     |
| Arthritis   | 70,500                    | Malignant Disease                | 8,900                     |
| Asthma  | 3,400                     | Metabolic Disease                | 2,800                     |
| Back Pain – Other/Precise Diagnosis not Specified | 40,100                    | Multisystem Disorders            | 2,500                     |
| Behavioural Disorder                              | 3,500                     | Multiple Sclerosis               | 9,900                     |
| Blindness   | 10,100                    | Neurological Diseases            | 20,100                    |
| Bowel and Stomach Disease                         | 2,400                     | Parkinson’s Disease              | 1,800                     |
| Cerebrovascular Disease                           | 13,200                    | Peripheral Vascular Disease      | 2,700                     |
| Chest Disease                                     | 10,500                    | Personality Disorder             | 6,300                     |
| Chronic Pain Syndromes                            | 17,200                    | Psychoneurosis                   | 52,700                    |
| Deafness  | 5,100                     | Psychosis                        | 73,100                    |
| Dementia  | 1,700                     | Renal Disorders                  | 3,400                     |
| Diabetes Mellitus                                 | 5,500                     | Severely Mentally Impaired       | 1,700                     |
| Diseases of the Muscles, Bones or Joints          | 28,000                    | Skin Disease                     | 1,900                     |
| Epilepsy  | 15,000                    | Spondylosis                      | 9,300                     |
| Heart Disease                                     | 10,500                    | Terminally Ill                   | 4,900                     |
| Hyperkinetic Syndrome                             | 7,900                     | Trauma to Limbs                  | 11,000                    |
| Inflammatory Bowel Disease                        | 1,900                     | Traumatic Paraplegia/Tetraplegia | 1,300                     |

Table 5. Count data for claimants by main disabling condition

### Defining mental illness

The variables in the data set selected to represent a range of mental health conditions for the purposes of this analysis were as follows:

- Alcohol and Drug Misuse
- Behavioural Disorder (incorporating conditions such as obsessive-compulsive disorder and eating disorders)
- Hyperkinetic Syndrome (now known as Attention Deficit Hyperactivity Disorder or ADHD)
- Personality Disorder
- Psychoneurosis (incorporating anxiety and mood disorders such as depression)
- Psychosis



## **Derived Variables**

**Psychiatric Condition:** This variable was created to enable a comparison between all claimants with mental health conditions compared to those with other illnesses and is categorical:

1=Alcohol and Drug Misuse, Behavioural Disorder, Hyperkinetic Syndrome, Personality Disorder, Psychoneurosis and Psychosis.

0=all other health conditions.

**Total Negative Outcome (Disadvantage):** This variable aimed to operationalise the concept of ‘disadvantage’ as specified in Hypothesis A. For the purposes of this analysis, disadvantage was defined as any financial reduction in entitlement compared to baseline DLA receipt. Similar descriptive calculations were used by Mind (2016). To create the variable, the count data for each of the assessment outcome categories: award decreased, award disallowed post-assessment and award disallowed pre-assessment (failure based on the initial paper application) was aggregated.

**Claims Withdrawn:** The assessment outcome category ‘Withdrawn’ proved problematic when defining negative outcomes since it is not possible to ascertain why individual claimants have decided to withdraw their application during the reassessment process, for example, the person may have decided that they no longer need the financial support because their illness has improved or they may feel unable to pursue the claim because of stressors associated with the process. Nevertheless, a calculation of the number of withdrawn claims demonstrates that these total no more than 1% for any individual health condition and therefore are unlikely to affect the outcome of the analysis.

Ultimately, the decision was taken to incorporate the ‘Withdrawn’ category into all other outcomes rather than the Total Negative Outcome variable. This is because the focus of the analysis is specifically on disadvantage and it is not possible to ascertain for certain that a withdrawn application is a negative outcome.

## 5.5. Limitations of the Dataset

**Individual characteristics:** Although data is available on demographic variables such as the age, gender and regional location of claimants, these data have not been incorporated into the summary information for health conditions, meaning that it is not possible to disaggregate the data and determine assessment outcomes for each health condition based on these individual characteristics. Attempts were made to incorporate this information into the dataset using the DWP StatXPlore online tool which holds administrative count data on benefit claimants but there appears to be no facility to create a dataset incorporating all these variables simultaneously. Overall summary information relating to the age of all claimants reassessed by outcome taken from DWP tables is available in Appendix 4.

**Variance:** The original data set includes count data for the total number of individuals reassessed by each health condition but specific assessment outcomes are presented as percentages of the total, all of which have been rounded to the closest 1%. This means data on total numbers of claimants reassessed and the individual assessment outcome categories (award increased, award unchanged and so on) do not fully correspond. This was a potential problem when converting the percentages for each assessment outcome back into count data to create the dataset. In order to assess the level of disparity between the reassessment totals and the count data derived from the percentages for each assessment outcome category, the converted count data was summed and compared to the overall reassessment totals. There was a difference between the totals in 21 of the included health conditions but the variance was no more than 1% for any single condition. It is unlikely therefore that the variance has had a significant impact on the analysis but caution must be exercised where differences between claimant groups are small.

## **5.6. Analysis strategy**

The likelihood of being a) financially disadvantaged and b) having a claim disallowed following an eligibility reassessment, compared to any other outcome was estimated for those with psychiatric conditions (exposed) relative to each of the non-psychiatric comparators (unexposed). Odds ratios and 95% confidence intervals were calculated using the immediate command ‘cci’ in Stata v15.1 (StataCorp, 2017). Odds ratios were selected because they are a relative measure that provides the capacity to compare outcomes across different health conditions. Given the lack of availability of data on individual demographic characteristics and other comparable information, the dataset does not lend itself to techniques such as regression modelling.

### **Hypothesis A**

In order to explore whether individuals with a mental illness experience differences in their outcomes of reassessment compared to claimants with other health conditions, odds ratios were calculated to determine whether there was an increased likelihood of an individual experiencing a financial disadvantage if their main disabling condition was psychiatric in nature, relative to claimants with other health conditions. Where the focus was on a singular mental health condition, all other mental health conditions were removed from the analysis in order that the outcomes were comparable. The 2x2 tables for each calculation are available in Appendix 5.

### **Hypothesis B**

Odds ratios were calculated to explore whether individuals with psychiatric conditions are more likely to have their claim disallowed following an eligibility assessment relative to non-psychiatric conditions. The 2x2 tables associated with each calculation are available in Appendix 5. For Hypothesis B and the further analysis undertaken (described below), the category ‘award disallowed post-referral to the assessment providers’ which refers to claims disallowed following an eligibility assessment was classified against all other reassessment outcomes.

### **Further Analysis**

The comparators used to explore hypotheses A and B represent a wide range of different physical health conditions and as such, do not offer much detail as to how

mental illnesses may differ in the eligibility assessment context. It is possible, for example, that some physical health conditions have very high rates of claims awarded following reassessment and if the data was examined in more detail, then physical conditions more similar to mental illnesses could actually have comparable rates of disallowed claims. This would suggest that it is not a disadvantage based on mental illness but on other aspects of mental illness that are problematic during the assessment process, for example, conditions that are invisible or do not lend themselves to a specific medical test.

In order to test this, further analysis was undertaken using the psychiatric conditions and three categories of non-psychiatric comparators. These included a 'musculoskeletal conditions' variable including claimants listing arthritis, back pain, diseases of muscles, bones and joints or spondylosis; a 'neurological conditions' comparator including multiple sclerosis and epilepsy, along with a third category of people with diabetes. These conditions were selected to represent a range of commonly reported, visible and non-visible, chronic and potentially relapsing health conditions.

# **Chapter 6: Cross-national comparative analysis**

## **6.1. Introduction**

This study focuses on exploring whether there is a relationship between both micro and macro socioeconomic factors and public attitudes towards people with mental illness. The limitations to research seeking to define the structural factors that are associated with public attitudes have been detailed in Chapter 3. Taking these limitations into consideration, I have chosen to use an alternative approach for this analysis.

Rather than exploring the association between policies and public attitudes towards mental illness (as with existing research seeking to determine the role of structural factors in experiences of the stigma associated with mental illness), this study aims to explore the relationship between public attitudes and the socioeconomic context of a country. Whereas policies arguably reflect the intentions of decision makers, spending decisions and other macro socioeconomic factors may give an indication of the actual ‘socioeconomic climate’ of a country for a resident with mental illness. A country may, for example, set out intentions for progressive mental health policies in terms of care and treatment whilst at the same time making economic decisions that perpetuate the socioeconomic disadvantages experienced by people with mental illnesses (Nelson et al., 2014).

Equally, there is a well-established relationship between macro socioeconomic factors and less tolerant attitudes towards marginalised groups such as immigrants, for example, where there is greater competition for economic resources, there is an association with higher levels of in-group/out-group prejudice (Bianchi, Hall and Lee, 2018). This relationship has not been tested in relation to attitudes towards people with mental illnesses but determining whether macro level socioeconomic factors are implicated in public stigma associated with mental illnesses is key to understanding how stigma may function, either intentionally or unintentionally, at the structural level.

Europe has been chosen as the location for the research primarily for practical reasons, because there is adequate data on both public attitudes and the proposed structural indicators to explore the research questions.

## **6.2. Aim and Research Questions**

### **Aim**

To explore the potential of structural socioeconomic factors to contribute to understanding differences in public attitudes towards people with mental illnesses across European countries.

### **Research Questions**

1. Are macro socioeconomic factors (GDP per capita, income inequality, disability poverty and social exclusion gap) associated with public attitudes towards mental illness across European countries?
2. Are mental health spending decisions associated with public attitudes towards mental illness across European countries and if so, is the relationship independent of GDP per capita and income inequality?
3. Are disability protection spending decisions associated with public attitudes towards mental illness across European countries and if so, is the relationship independent of GDP per capita and income inequality?

## **6.3. Outcome Variable**

The outcome variable for all analyses is taken from the Eurobarometer 2010, a cross-national survey conducted annually and for this particular year, including data on attitudes towards people with mental illness for approximately 26,800 individuals across 27 European countries (Eurobarometer, 2010). The sample was drawn using multi-stage random probability sampling proportional to population size and density and is representative of the population aged 15 and above in each of the countries (TNS Opinion and Social, 2010). Interviews were carried out face to face at participant homes in an appropriate national language (TNS Opinion and Social, 2010).

The survey used for this analysis represents the second in a special series about mental health across Europe with the first survey taking place in 2006; however, the 2010 survey is the first to explore perceptions of people with mental illness

(Eurobarometer, 2010). There is one question in the survey exploring perceptions and this will be used as the outcome variable for this analysis:

|                     |   |   |            |               |
|---------------------|---|---|------------|---------------|
| Outcome variable    | Which of the following two statements best describe how you feel?                       |   |            |               |
| Response categories | You would find it difficult talking to someone with a significant mental health problem | You would have no problem talking to someone with a significant mental health problem | Don't know | Inappropriate |

Table 6. Outcome variable response categories

Answers are coded as a continuous variable in the data set, however it was felt that recoding the data into a categorical format would improve interpretation, given that answers are defined as would have difficulty/would not have difficulty/don't know and each represents a distinct response. A new variable was derived from the data with 0=no problem talking to someone with a significant mental health problem and 1=difficulty talking to someone with a significant mental health problem. The Eurobarometer dataset has been coded so that 'Don't know' is treated as missing for the purposes of analysis and there were no 'Inappropriate' values for the outcome variable.

Although it is arguable that there may have been changes to attitudes towards people with mental illness since 2010, especially given the increased focus on anti-stigma campaigns in countries such as the United Kingdom (Evans-Lacko et al., 2014), to the best of my knowledge the 2010 Eurobarometer represents the most recently available cross-national European data exploring perceptions of people with mental illness with a large enough sample size to allow for detailed analysis of structural factors. Given that there is some evidence of an association between economic recession and stigmatising attitudes (Evans-Lacko et al., 2013); it is possible that the timing of the survey may produce different results than an analysis undertaken more recently. The research, however, seeks to explore the role of socioeconomic factors in the post-recession context specifically and so the analysis is appropriate to the thesis aims.



## 6.4. Covariates

Individual demographic variables were sourced from the Eurobarometer dataset and country level variables were derived from other publicly available data sources (Table 7).

| Variable   | Data Source   |
|--|---|
| <b>Compositional factors</b>   |   |
| Gender   | Eurobarometer   |
| Age  | Eurobarometer   |
| Income   | Eurobarometer   |
| Area of Residence  | Eurobarometer   |
| <b>Contextual factors</b>  |   |
| Country  | Eurobarometer   |
| Mental health spending as a proportion of overall health spending        | WHO mental health atlas 2005                              |
| Mental health spending as a proportion of overall health spending        | WHO mental health atlas 2011 (2009/10 spending estimates) |
| Mental health spending as a proportion of overall health spending change | Calculated  |
| Disability protection spending – Purchasing Power Standard               | EU-SILC survey 2006                                       |
| Disability protection spending – Purchasing Power Standard               | EU-SILC survey 2010                                       |
| Disability protection spending change – Purchasing Power Standard        | Calculated  |
| Disability poverty and social exclusion gap (%)                          | EU-SILC survey 2010                                       |
| Income inequality  | Eurostat  |
| GDP per capita   | Eurostat  |

Table 7. Data sources for independent variables

### 6.4.1. Compositional factors

Age and gender were included in the analyses since these factors are known to impact on individual perceptions of people with mental illness (Stickney et al., 2012).

Individual financial circumstances were included in the analyses because understanding the association between micro socioeconomic factors and stigma is in

keeping with the overall thesis aims. Further to this, existing research suggests a link between recession and stigmatising attitudes (Evans-Lacko et al., 2013) and so individual financial circumstances could also be implicated in any relationship between macro socioeconomic factors and public attitudes.

Perceptions of income act as a relative indicator of deprivation that enables a comparison across different national contexts and so this variable was included as a measure of individual financial circumstances rather than traditional indicators of socioeconomic status. Occupation is an imprecise measure of financial circumstances because ‘unemployed’ categories also incorporate students, stay at home carers and those who are retired, all of whom may have quite different socioeconomic backgrounds. Similarly, without details of the specific context of each country, it is difficult to ascertain how level of education might affect employment prospects.

Area of residence was included initially as a compositional factor since greater tolerance towards people with mental illness is associated with higher levels of social contact (Thornicroft et al., 2016), which may be affected by whether a person lives in an urban or rural setting, but this was removed after initial logistic regression analysis demonstrated that it was not contributing any information to the models and goodness of fit was improved once it was removed. Ethnicity was not included as an individual variable because across a European sample this would represent a prohibitively large number of categories. Further discussion on ethnicity and implications for the research is included in Chapter 10.

All of the demographic variables included in the analysis are in categorical format in the original data set (Eurobarometer, 2010), each are outlined in Table 8 with reference categories indicated.

| Age                        | Gender                    | Financial circumstances<br><i>During the last 12 months, would you say you have had difficulties to pay your bills at the end of the month?</i> |
|----------------------------|---------------------------|---|
| 16-25 (reference category) | Male (reference category) | Almost never/never (reference category)   |
| 25-39                      | Female                    | From time to time   |
| 40-54                      |                           | Most of the time  |
| 55 and above               |                           |   |

Table 8. Response categories for compositional factor variables

#### 6.4.2. Contextual factors

One of the challenges of exploring contextual factors for this study was in identifying key macro socioeconomic variables and subsequently translating these across multiple national contexts. This was achieved in several ways. Firstly, as it is beyond the scope of the thesis to study all possible macro socioeconomic factors that may be implicated in public attitudes towards people with mental illness, contextual variables were selected based on salient indicators that could impact on the socioeconomic climate for people with mental illnesses, derived from the literature discussed earlier in the thesis (Chapters 1-3).

The main macro socioeconomic factors selected for the study were GDP per capita, income inequality, the disability poverty and social exclusion gap, alongside mental health and disability protection spending. GDP per capita represents the overall financial resources available to a country whilst income inequality demonstrates how these resources are distributed in the population. The disability poverty and social exclusion gap has been selected to represent an overall measure of barriers to socioeconomic inclusion for people with disabilities compared to the general population.

Each of the contextual factors described here were analysed (results are available in Chapter 9) both with and without GDP per capita initially, because of the potential for overall levels of economic resources to act as a confounder for other macro socioeconomic factors. After demonstrating consistent associations in each of the initial logistic regression models, income inequality was also included in each of the

final models for the same reason. Doing so meant that associations between spending decisions and attitudes towards people with mental illness could be explored independently of these factors.

In order to explore the role of contextual factors and ensure these were comparable across the differing economic conditions of each country, a series of standardised measures were used. Variables were selected from publicly available European country-level socioeconomic data derived from a variety of sources (Table 7) and the values assigned to each country were then added to the existing Eurobarometer dataset as new variables for the purposes of analysis. Each contextual covariate is described in detail in the next section.

### **Mental health spending**

Data to create these variables were extracted from the World Health Organisation Mental Health Atlas which provides information on mental health systems within countries. This includes details on mental health policies, financing and information systems, staffing and other resources such as medicines and availability of psychiatric facilities (World Health Organisation, 2018). Included in both the 2005 and 2011 versions of the Atlas is a calculation of the proportion of spending on mental health in relation to the overall health budget of a country, self-reported. In the 2011 Atlas, spending is listed as 2009/2010 estimates (World Health Organisation, 2018) and will be referred to as 2010 spending estimates in the analysis for clarity. This measure was selected because the focus of the analysis is on whether spending decisions are associated with public attitudes towards people with mental illness and spending as a proportion of the overall health budget demonstrates the level of priority a government ascribes to mental health with the funds it has available. Alongside the data extracted directly from the Mental Health Atlas, a further variable was created to represent spending change over time by calculating the difference between the proportion of spending in 2005 and 2010. This variable is designed to explore whether increases or decreases in spending are associated with differences in attitudes towards people with mental illness. Consistent data on mental health spending was only available for 13 countries in the EU27 (Table 9), meaning that all analyses including this variable relate to 13 rather than 27 countries.

### **Disability protection spending**

This variable was selected as an indicator of welfare spending on people with long term health conditions. In the United Kingdom, reductions in welfare spending have until recently received widespread public support and accompanying narratives may be associated with increased stigma for people with disabilities (UNCRPD, 2016). It is possible therefore, that where there has been a reduction in spending, this may be associated with more negative attitudes towards people with disabilities, in this case, individuals with mental illness. Disability protection spending figures have been extracted from the Eurostat database and change over time calculated as the difference between 2006 and 2010 figures for each country (Eurostat, 2018). Purchasing Power Standard has been used as the unit of measurement for this analysis because it is a standardised measure across the countries in the sample (Eurostat, 2018).

### **Disability poverty and social exclusion gap**

This indicator, derived from the EU-SILC survey, measures the difference between the proportion of people with and without a disability experiencing poverty and social exclusion. Disability is defined as a “limitation in activities people usually do because of health problems for at least the past six months” (Eurostat, 2018) and poverty and social exclusion is calculated from a combination of people at risk of poverty after social transfers, material deprivation and households with low work intensity (Eurostat, 2018). This indicator provides information about the living circumstances of people with disabilities and measures inclusivity in economic terms. Although focusing more broadly on people with disabilities, it does incorporate people with mental illnesses and gives an indication as to the context of life with a disability in each of the countries.

### **Income inequality and GDP per capita**

These indicators represent macro-economic factors with the potential to impact on public attitudes. Income inequality is measured here by the 2010 Gini coefficient for each of the countries, derived from Eurostat (Eurostat, 2018). Data on GDP per capita was also collected from Eurostat and measured in Euros to enable standardised comparison.

## **6.5. Dataset**

In the first instance, the Eurobarometer dataset including compositional variables and the outcome variable was downloaded to Stata version 15.1 (Statacorp, 2017) for analysis. All Eurobarometer data was weighted using the EU27 population weight included in the dataset (Eurobarometer, 2010). Information for each of the contextual variables was collated from the respective datasets as described in the previous section and a database of this information was created before being migrated to Stata and added to the Eurobarometer data. Cross-tabulation was used to check that all values were correctly assigned to each country prior to carrying out any analysis. The values for each of the contextual variables, including those generated independently (spending change) are available in Table 9.

|                        | <b>Disability Poverty and Social exclusion gap (%) 2010</b> | <b>Gini co-efficient 2010</b> | <b>GDP per capita 2010 (Euros)</b> |
|------------------------|---|-------------------------------|------------------------------------|
| <b>Belgium</b>         | 16.4  | 26.6                          | 33,500                             |
| <b>Bulgaria</b>        | 21  | 33.2                          | 5,100                              |
| <b>Czech Republic</b>  | 8.2   | 24.9                          | 14,900                             |
| <b>France</b>          | 6.9   | 26.9                          | 30,800                             |
| <b>Cyprus</b>          | 20.9  | 30.1                          | 23,300                             |
| <b>Latvia</b>          | 13  | 35.9                          | 8,500                              |
| <b>Luxembourg</b>      | 6.6   | 27.9                          | 79,200                             |
| <b>Hungary</b>         | 9   | 24.1                          | 9,900                              |
| <b>Malta</b>           | 10.2  | 28.6                          | 15,900                             |
| <b>The Netherlands</b> | 8.8   | 25.5                          | 38,000                             |
| <b>Portugal</b>        | 15  | 33.7                          | 17,000                             |
| <b>Sweden</b>          | 10.6  | 25.5                          | 39,400                             |
| <b>United Kingdom</b>  | 15  | 32.9                          | 29,300                             |
| <b>Austria</b>         | 10.3  | 28.3                          | 35,400                             |
| <b>Denmark</b>         | 10.9  | 26.9                          | 43,800                             |
| <b>Germany</b>         | 8.9   | 29.3                          | 32,100                             |
| <b>Estonia</b>         | 10  | 31.3                          | 11,000                             |
| <b>Greece</b>          | 9.6   | 32.9                          | 20,300                             |
| <b>Spain</b>           | 5.6   | 33.5                          | 23,200                             |
| <b>Ireland</b>         | 11.9  | 30.7                          | 36,800                             |
| <b>Italy</b>           | 5.1   | 31.7                          | 26,800                             |
| <b>Lithuania</b>       | 9   | 37                            | 9,000                              |
| <b>Poland</b>          | 10.8  | 31.1                          | 9,400                              |
| <b>Romania</b>         | 9.8   | 33.5                          | 6,200                              |
| <b>Slovenia</b>        | 14.1  | 23.8                          | 17,700                             |
| <b>Slovakia</b>        | 6.4   | 25.9                          | 12,400                             |
| <b>Finland</b>         | 8.9   | 25.4                          | 34,900                             |

Table 9. Contextual factor values by country.

|                 | 2005 Mental health spending (%) | 2010 Mental health spending (%) | Mental health spending change (%) | 2006 Disability protection spending (PPS) | 2010 Disability protection spending (PPS) | Disability protection spending change |
|-----------------|---------------------------------|---------------------------------|-----------------------------------|---|---|---------------------------------------|
| Belgium         | 6                               | 6                               | 0                                 | 503.88                                    | 584.81                                    | 80.93                                 |
| Bulgaria        | 2.5                             | 1.4                             | -1.1                              | 112.14                                    | 142.91                                    | 30.77                                 |
| Czech Republic  | 3                               | 2.9                             | -0.1                              | 296.1                                     | 327.16                                    | 31.06                                 |
| France          | 8                               | 12.91                           | 4.91                              | 505.33                                    | 538.37                                    | 33.04                                 |
| Cyprus          | 7                               | 4.82                            | -2.18                             | 153.89                                    | 165.07                                    | 11.18                                 |
| Latvia          | 6.3                             | 5.9                             | -0.4                              | 109.3                                     | 185.67                                    | 76.37                                 |
| Luxembourg      | 13.4                            | 13.4                            | 0                                 | 1605.86                                   | 1464.73                                   | -141.13                               |
| Hungary         | 8                               | 5.1                             | -2.9                              | 339                                       | 313.51                                    | -25.49                                |
| Malta           | 10                              | 6.71                            | -3.29                             | 201.42                                    | 167.61                                    | -33.81                                |
| The Netherlands | 7                               | 10.65                           | 3.65                              | 748.84                                    | 801.09                                    | 52.25                                 |
| Portugal        | 2.3                             | 5.24                            | 2.94                              | 437.51                                    | 398.81                                    | -38.7                                 |
| Sweden          | 11                              | 10.5                            | -0.5                              | 1295.38                                   | 1202.96                                   | -92.42                                |
| United Kingdom  | 10                              | 10.82                           | 0.82                              | 617.18                                    | 512.24                                    | -104.94                               |
| Austria         |                                 |                                 |                                   | 682.15                                    | 693.88                                    | 11.73                                 |
| Denmark         |                                 |                                 |                                   | 1223.71                                   | 1328.19                                   | 104.48                                |
| Germany         |                                 |                                 |                                   | 615.27                                    | 674.75                                    | 59.48                                 |
| Estonia         |                                 |                                 |                                   | 184.48                                    | 317.55                                    | 133.07                                |
| Greece          |                                 |                                 |                                   | 273.86                                    | 346.15                                    | 72.29                                 |
| Spain           |                                 |                                 |                                   | 378.01                                    | 408.91                                    | 30.9                                  |
| Ireland         |                                 |                                 |                                   | 304.65                                    | 378.57                                    | 73.92                                 |
| Italy           |                                 |                                 |                                   | 357.88                                    | 424.07                                    | 66.19                                 |
| Lithuania       |                                 |                                 |                                   | 192.49                                    | 285.97                                    | 93.48                                 |
| Poland          |                                 |                                 |                                   | 265.49                                    | 286.9                                     | 21.41                                 |
| Romania         |                                 |                                 |                                   | 103.07                                    | 208.16                                    | 105.09                                |
| Slovenia        |                                 |                                 |                                   | 389.9                                     | 361.09                                    | -28.81                                |
| Slovakia        |                                 |                                 |                                   | 212.24                                    | 307.02                                    | 94.78                                 |
| Finland         |                                 |                                 |                                   | 855.82                                    | 995.56                                    | 139.74                                |

Table 9 (continued). Contextual factor values by country.



## **6.6. Logistic and multilevel logistic regression modelling**

Multilevel regression modelling is a useful technique for analysing data in which individuals are clustered in groups and originated in educational research to account for school as well as individual pupil effects when measuring outcomes, for example, exam results may be due to individual levels of attainment, but these may also be affected by the school the child attends. Individual observations do not meet the statistical assumption of independence because people are affected by the context in which they are situated, and this needs to be accounted for during data analysis (Twisk, 2006). Multilevel techniques have been increasingly employed in cross-national comparative research (Bryan and Jenkins, 2016).

Given that both individual and contextual factors may influence public attitudes towards mental illness, it is proposed that multilevel modelling may be the most appropriate approach to explore the research questions. There is ongoing debate about the acceptable number of contextual factors in multilevel models and caution must be exercised when using cross-national data, particularly when multiple contextual variables are used and in logistic regression modelling, where diagnostics to determine whether the model is a good fit are limited (Mohring, 2012). In an extensive review of cross-national analyses where multilevel modelling has been used, Bryan and Jenkins (2016) recommend that data from upwards of 25 countries should be included to generate reliable estimates. Whilst this series of analyses focused primarily on 27 countries, mental health spending data was only available for 13 countries, meaning that the reliability of the findings could be compromised. The implications for the analyses that included mental health spending are discussed further in Chapter 9.

As the outcome variable here is categorical and multilevel logistic regression was used, several methods were employed to assess goodness of fit. Firstly, comparisons were made for all analyses between standard logistic regression models and multilevel logistic regression models in order to assess whether accounting for country level effects through the use of a multilevel structure provided a better fit for the data than a standard logistic regression model. Secondly, compositional variables were added to the models first followed by contextual variables so that the effects of both on the models could be examined separately.

## 6.7. Analytic Strategy

Data was weighted using the EU27 population weights available with the dataset (Eurobarometer, 2010) for all models. Analyses were conducted in Stata version 15.1 (StataCorp, 2017). For logistic regression models, the command ‘logit’ was used and for multilevel models, the command ‘melogit’ was employed, with data grouped by country. Findings were converted to odds ratios for all analyses using the additional command ‘or’. Intraclass correlations for multilevel models were estimated using the command ‘estat icc’. Graphs and correlations were used in the first instance to explore the relationship between the outcome variable and each of the contextual factor variables; these are available in Appendix 6.

### Initial logistic regression models

| <b>Model</b>  | <b>Compositional covariates</b> | <b>Contextual covariates</b>   |
|---------------|---------------------------------|--|
| <b>1</b>      | age, gender, financial status   |  |
| <b>2a(i)</b>  | age, gender, financial status   | Mental health spending (2005)<br>Mental health spending change (2005-2010)   |
| <b>2a(ii)</b> | age, gender, financial status   | Mental health spending (2005)<br>Mental health spending change (2005-2010)<br>GDP per capita                               |
| <b>2b(i)</b>  | age, gender, financial status   | Disability social protection spending (2006)<br>Disability social protection spending change (2006-2010)                   |
| <b>2b(ii)</b> | age, gender, financial status   | Disability social protection spending (2006)<br>Disability social protection spending change (2006-2010)<br>GDP per capita |
| <b>2c(i)</b>  | age, gender, financial status   | Disability poverty and social exclusion gap  |
| <b>2c(ii)</b> | age, gender, financial status   | Disability poverty and social exclusion gap<br>GDP per capita  |
| <b>2d(i)</b>  | age, gender, financial status   | Income inequality  |
| <b>2d(ii)</b> | age, gender, financial status   | Income inequality<br>GDP per capita  |

Table 10. Analysis strategy: Initial logistic regression models

The models were reviewed after this initial stage. Disability social protection spending, whilst statistically significant, was observed to have no effect (OR: 1.00, 95% CI: 1.00, 1.00) when GDP per capita was added to the model and so the decision was made not to include this variable in later analysis. Effects for mental health spending, disability poverty and social exclusion gap, income inequality and GDP per capita were maintained in each of the logistic regression models and were subsequently taken forward for multilevel logistic regression models.

| <b>Model</b> | <b>Compositional factors</b>  | <b>Contextual factors</b>   |
|--------------|-------------------------------|---|
| 2a(iii)      | age, gender, financial status | Mental health spending (2005)<br>Mental health spending change (2005-2010)<br>GDP per capita<br>Income inequality |
| 2c(iii)      | age, gender, financial status | Disability poverty and social exclusion gap<br>GDP per capita<br>Income inequality                                |
| 2d(iii)      | age, gender, financial status | Income inequality<br>GDP per capita   |

Table 11. Analysis strategy: Final models

The final models are outlined in Table 11. Numbering of the models has been continued from the logistic regression models outlined in Table 10. For each of the final models, standard and multilevel logistic regression models were compared to assess whether a multilevel structure was preferable, the associated tables are available in Appendix 7.

Chapter 9 outlines the results primarily for these three final models but also reports on initial correlations between contextual factors and the outcome variable and the comparison between standard logistic and multilevel models, before ending with a discussion of the key findings.

## **Conclusion**

The methodology section has outlined the research process and design for each of the planned studies, including setting out methodological challenges. It has aimed to situate the research in the theoretical framework and by identifying gaps in the literature, outline how each piece of research can potentially contribute to the existing evidence base.

The interview study aims to explore the lived experiences of claimants of health-related income benefits with a mental illness and seeks to discover whether interpersonal stigma is present in this context. By analysing claimant administrative data, the aim of the second study is to assess whether financial disadvantage is visible in extra-cost disability benefit outcomes for people with mental illnesses, as compared to those with other health conditions. Finally, the third study will focus on the association between broader socioeconomic factors and public attitudes towards people with mental illnesses. The aim here is to explore some of the possible structural socioeconomic drivers of public attitudes and to assess for the socioeconomic conditions under which prejudice may be increased or decreased.

Overall, the research aims to consider both micro and macro level drivers of stigma in relation to socioeconomic factors and mental illness, using the post-2007 recession context to explore whether the broader socioeconomic climate is related to the stigma associated with mental illness. The next section of the thesis will report on the analysis and findings of each of the studies. A separate discussion is included in each chapter, followed by an overall discussion in Chapter 10 drawing overarching themes from the research together and considering these in relation to the broader aims of the thesis.

## Section C: Results

## **Introduction**

This section will outline the findings for each of three studies designed to address the overall thesis aims.

Chapter 7 discusses an interview study undertaken with people experiencing mental illness, focusing on lived experiences of claiming health-related income benefits. Data analysis is approached using a thematic analysis framework. Key themes emerging from the analysis are discussed, both in relation to the claims process and in relation to participant perceptions of stigma.

Chapter 8 discusses a study undertaken using administrative data on claimants undergoing reassessment from Disability Living Allowance to Personal Independence Payments between 2013 and 2016. It considers whether claimants with mental illnesses experience an overall financial disadvantage following this transfer compared to claimants with other health conditions. In keeping with the existing literature and findings from the interview study, in which claimants with mental illnesses describe problematic eligibility assessments, the analyses also consider the eligibility assessment component of the claims process specifically and whether there are differences in outcomes by health condition. The chapter reports on comparisons between claimants with mental illnesses and those with a range of physical health conditions, followed by a comparison between claimants with mental illnesses and a range of selected health conditions, designed to mirror particular characteristics of mental illness.

Chapter 9 moves to a cross-national comparative analysis and reports on a series of logistic regression models, both standard and multilevel, designed to explore the relationship between structural economic factors and public attitudes towards people with mental illness. The findings consider the role of individual demographic factors, socioeconomic conditions and public spending decisions, aiming to explore whether there is an association between these macro-economic factors and public attitudes towards mental illness.

In keeping with the epistemological position of critical realism outlined in the methodology section, the discussion sections in each chapter will outline the direct findings and also use researcher led inference to explore how the results may fit in

with underlying structures and meanings, linking back to the theoretical model underpinning the thesis.

## **Chapter 7: “Unseen Injuries”: Lived experiences of welfare reform**



## **7.1. Introduction**

This chapter details the key findings of an interview study designed to explore the lived experiences of people with mental illnesses who were accessing health-related income benefits. The methods and reflective account associated with the research are detailed in Chapter 4 of Section B of the thesis. The chapter discusses experiences and outcomes of the claims process itself; before moving to substantive themes emerging from the thematic analysis. The aim of this study was to explore experiences of stigma in this context and so this is considered specifically as part of the findings. This section is followed by a discussion comparing the findings with existing evidence and outlining the limitations of the study. Finally the implications of the findings are considered.

## **7.2. Findings**

### **7.2.1. The claims process**

This section will provide an overview of the experiences of accessing health related income benefits reported by participants. Since housing benefit is provided automatically for anyone who is accessing income benefits, this will not be discussed separately. However, it is worth noting that four of the participants did report some form of difficulty with accessing appropriate housing.

Out of eighteen individuals in the sample, eleven had been turned down for one or more health related income benefits, either Employment Support Allowance (ESA), Personal Independence Payments (PIP) or the PIP predecessor, Disability Living Allowance (DLA).

Of these eleven participants, four had appealed this decision and all had been successful in having their benefits reinstated, a further participant was in the process of appealing at time of interview. Two participants did not appeal the decision and began the process of looking for work but decided to reapply and undertake a further Work Capability Assessment following advice from their job centre worker after they appeared too unwell to be searching for employment. After repeating the

process, one participant moved to the ESA support group and one participant was awaiting the outcome of this second assessment at time of interview.

Four individuals had been deemed Fit for Work and moved on to Job Seekers Allowance (JSA) so were searching for employment at the time of the study. Two participants found this to be acceptable, Robert had recently been made redundant and was hoping to re-join the workforce as quickly as possible. Another individual, Margaret had been searching for a job for eight years without success but maintained the perspective that she should actively seek work if she expected to receive money from the state. Two individuals found actively searching for work to be a stressful process that they felt unable to cope with in their current state of health. Thomas stated that he had been through multiple assessments but had been declared Fit for Work on each occasion, although reportedly his General Practitioner disagreed with this outcome. Thomas described being under an increasing threat of sanctions because he was unable to keep up with the job centre work search requirements, exacerbated by having a lack of internet access at home and being a forty-five-minute bus journey away from the job centre. David reported a pattern of failing to meet his requirements to look for work or attend job centre appointments, being sanctioned and then returning to his doctor for a sick note. After this, he would attend a Work Capability Assessment, be declared Fit for Work and subsequently return to looking for employment in a continuous cycle.

Six participants in the sample reported that the process of accessing benefits had been acceptable. Five individuals reported that they had attended their assessment with a healthcare worker or had written evidence from mental health services to support their claim which had assisted with the process. One participant had attended the assessment independently and had been placed into the ESA support group.

The final participant in the sample, Peter had been assessed as being able to look for work within the year, so had joined the Work-Related Activity Group. Peter had so far found this to be a positive process and was looking forward to receiving the support available. He had had a long career in customer service prior to his illness and at the time of our interview, had been booked on to a confidence building course as a first step.

The next section of the findings outlines further key themes from the research. Participant quotes are each highlighted in italics with accompanying pseudonyms. In each case, R=Researcher.

### 7.2.2. Perceptions of eligibility assessments

The eligibility assessment process was frequently stressful for participants because even when it transpired that the appointment itself was uneventful and the person did receive financial support, anecdote and negative media coverage had led people to believe they would experience difficulties. Most participants described high levels of anxiety before and during their appointment, with several reporting they were unable to leave the house beforehand without the support of family members. The assessment itself was also described as daunting and stressful, as Alan reports of his PIP assessment:

*Alan: For the assessment and, and I felt phys-, I was ill, I was sick during the interview.*

*R: Oh, were you?*

*Alan: Yeah, yeah.*

*R: Oh, why was that?*

*Alan: Because it was so nerve-racking you know, I've heard so many bad things about the, the, they call it ATOS or something, have you heard of them?*

*R: Oh yeah, the company that does it, yeah.*

*Alan: Yeah, and I heard, heard so many bad things about...about that and I thought oh God almighty, at, at one stage I was just going to abandon it and think well I don't, I don't need, yeah it'd come in handy but I don't need this, this extra money that bad to put myself through that.*

The level of scrutiny during the interviews was particularly problematic and participants felt there was an underlying assumption that their claim was fraudulent and must be proven otherwise. Participants invariably framed the assessment in terms of pass or failure and felt that their personal performance would influence the outcome, either through politeness and compliance or through emphasising the symptoms of their illness. Similar findings are reported by Shefer et al. (2016) in a study of claimants with mental health issues who had been turned down for sickness benefits. Although the assessment is designed to be a standalone, objective assessment of health and capability, it is clear that claimants did not view it this way and based on the findings already discussed in relation to access, the input of a healthcare professional did appear to be beneficial in this respect.

It was not possible in the study to compare baseline level of need; however there did not appear to be any link between a greater likelihood of success in receiving a financial award and severity of illness. Louise for example, who had at the time of her assessment recently left 24 hour supported accommodation, was receiving intensive community support and had a longstanding diagnosis of schizophrenia alongside a learning disability, was unsuccessful, whilst Alan who was in part time work and described himself as relatively high functioning most of the time, was successful.

### **Assessing Capability**

The content of the assessment itself was the issue most frequently highlighted in the study as problematic. Participants reported that the questions they were asked overwhelmingly focused on physical health and there was little opportunity within these set parameters to discuss the impact of their mental illness on everyday life. This meant that achieving the number of points necessary to receive financial support was perceived to be more difficult, as Jane and David discuss:

*R: And what about in terms of the type of questions that they ask?*

*Jane: Absolutely...I've never heard nothing like it, can you turn a light switch on? What the hell has that got to do with what's going on in my head?*

*R: Right, yeah, yeah.*

*Jane: I said that to her, I said "there's nowt wrong with my arms and legs".*

*R: Yeah, yeah.*

*Jane: It's my head what's..there's some-at wrong.*

\*\*\*\*\*

*David: And erm...erm..I failed..you know. I can, I can, well of course, I can get up in the morning, I can feed myself.*

Eligibility assessments have been through several iterations over the past twenty years and concerns have been raised by commentators that these do not directly address the difficulties caused by mental illness in daily life (Callanan, 2011; Abdul-Hamid and Bhui, 2014), therefore disadvantaging claimants with this type of health condition. Policy makers have argued that the most recent approach represents a shift away from focusing on deficit and towards ability, supporting what the individual

*can* do rather than what the illness may prevent the person from doing (Department of Work and Pensions, 2011) but claimants here suggested that physical capability was prioritised.

*Alan: So yeah, erm...so yeah, it makes me feel vulnerable that they're going to change things and withdraw support for people yeah.*

*R: Okay.*

*Alan: Yeah it does, very vulnerable and secondly, it, it just makes you feel stigmatised and because people can't see your disability, you know erm..because obviously when I'm well, yes I'm able to walk around and do things but literally when I'm not well, Katie, I, I couldn't even make a cup of tea, I might as well be paralysed.*

Although some participants did report that their mental health was discussed during their assessment, there was inconsistency across the sample as to whether this occurred and if so, then the level of detail. This suggests a disparity between the procedure itself, which has been designed to incorporate some assessment of mental health and actual experience. When mental health was discussed, where traumatic experiences had caused the illness, repeating this information to provide proof of illness was distressing. This particularly affected claimants with a mental illness because these conditions are more likely to be invisible and few individuals in the sample had access to a psychiatric team to provide written evidence.

### **7.2.3. Perceptions of Conditionality**

Conditionality refers to a set of requirements claimants must adhere to in order to continue receiving their financial support. This may include for example, attending certain appointments or searching for employment, depending on the benefit. If a person does not adhere to these requirements, they may receive a sanction in which their financial entitlement is stopped for a specified timeframe.

Conditionality in this study was overwhelmingly perceived as a form of financial control designed to maintain power over claimants. Although few participants had actually received a sanction, the fear of financial support being removed was pervasive throughout the experience of using the welfare system, acting as an

implied threat. This meant that even where interventions were designed to be collaborative and voluntary participants felt bound to comply, as Peter and Jenny describe:

*R: Yeah, so is the job group, is the job club voluntary?*

*Peter: Well it's not voluntary, is it? They tell you it is but it isn't, you know, you're dependent on that to get your money...*

\*\*\*\*\*

*Jenny: Basically, everything that you get put in front of you from the job centre is mandatory, nothing is voluntary.*

*R: Right, okay.*

*Jenny: Do it or you get sanctioned, do it or you lose your money, do it or you lose your money.*

*R: Right, right.*

*Jenny: And what scares me is I've got a house so if all my benefit goes, I'm made homeless.*

Margaret had been unemployed and on JSA for eight years at the time of our interview so had attended all the back to work skills training courses several times, for example, learning how to write a CV, but felt compelled to continue attending because of the possible implications of challenging the requirements placed on her.

*Margaret: But you know everything that they're going on but you can't turn round and say no because if you do that..then..you're in trouble because then you, you sort of don't go on their courses and then if you, if you don't do that then your erm, allowance if that's what you want to call it, your income then will stop because you're not going on the-, so..it's swings and roundabouts.*

Alongside acting as a covert form of coercion, the fear that money could be withdrawn at any time caused sustained anxiety and stress, particularly where illness meant that a return to work was not likely in the foreseeable future. Three participants reported suicidal thoughts in relation to the withdrawal of their financial support.

*Joseph: You know, I can honestly admit that, I can't cope with the pressure...I think I've got a bit of sorting mesen out first, you know what I mean like.*

*R: Right, right, so when you say, is that, you find it difficult to cope with actually going down there and..*

*Joseph: Yeah, yeah you know, sorta....that sorta stuff and that threat of sanctioning if you mess up all the time and...you know....*

\*\*\*\*\*

*Sarah: They can push me to s-, they can push me...the only way they can push me is...am I going to sit here and turn round and say have I ever contemplated suicide? Yeah, thousands of times..and would I put it into practice?...No.*

*R: Yeah, yeah.*

*Sarah: And I think the only reason I wouldn't put it into practice is m-, 'cause I'm frightened to death of dying...I think if I wasn't a person who was frightened to death of dying....there's many out there who are killing themselves to this day because they're having their benefits took from under their feet constantly....because they're told that they're normal and they're alright and they can go out to work.*

The same perception of coercion was also reported by participants during the initial assessment process, through requests for information the person would not otherwise choose to disclose, suggesting an extended reach of conditionality beyond formal mechanisms. This is particularly problematic where an illness may be caused by difficult life events or trauma as Callum reports:

*R: Right, so in that assessment they were saying to you "if you don't answer this question then..."-*

*Callum: (at same time) If you don't answer this question, then your money could be stopped, and it felt like I were being held to ransom.*

*R: Right.*

*Callum: You know, things that I didn't want to tell them they were making me tell them and it's like, well I don't want to tell you about these things it's personal.*



## **Transport as a hidden cost of conditionality**

Although financial support was contingent on meeting certain requirements set by the job centre, for example, attending appointments, medical assessments or job search activities, participants were expected to cover these costs from their payments. For participants who did not have a disability bus pass, this was an added pressure on an already low income. Some of the interviews during the study took place at the homes of participants and here it was evident that the main city resources were at least a bus journey away.

*Jenny: And they send you off like to (place) and stuff to do groundworks and you've got to fund out your what...hundred and twenty pound a fortnight money.*

*R: Oh right. You've got to go-*

*Jenny: So they do actually make you do things.*

*R: Yeah.*

*Jenny: But it's ridiculous what they're asking you to do.*

*R: Right, so you think it's too much.*

*Jenny: They make, when I was on Jobseekers they made me go and work at (building merchants) for a full two weeks full time work, just from my Jobseekers allowance.*

\*\*\*\*\*

*Margaret: The minute that erm, they say that I don't need the pass....then I'm sort of stuck because then I'm going to have to on-, only go out when it's really necessary...*

*R: Mmm.*

*Margaret: Right...which then of course I'll have the er, job centre on me back because I won't be sort of looking for the j-, looking for the jobs that as much as I can...*

*R: I see, so having that pass allows you to do what the job centre's asking you to do..*

*Margaret: Yeah, yeah.*

*R: But if you didn't have it that would be difficult.*

*Margaret: Oh yeah, yeah...and then of course you see, then....I would have to sort of take my, some of my finances would be cut even, even more so because I would sort*

*of need monies that f-, c-, I would need some money to sort of go travelling into sort of town..or any other town when (coughs)...when I have to do it.*

#### **7.2.4. Bureaucratic procedures**

Participants understood the need to collect and process their personal information in order to receive financial support, however, at times the system was confusing to navigate. In addition to this, mental health sometimes prevented people from keeping up with the large amount of correspondence, participants with depression for example reported that during periods of low mood, they often left letters unopened. This had consequences for financial support if appointments were missed as a result. Bureaucracy was however most commonly discussed in terms of participants not being treated as individuals and the phrase ‘box ticking’ was used on multiple occasions to refer to this, as Clare and Joseph report:

*Clare: I don't want to share with 'em me private life, that you know, I'm feeling a bit crap now 'cause ABC, that's just adding on to the...but then still that you're ticking certain boxes, criteria.*

*R: Right. So you feel like you're having to sort of share information that you wouldn't necessarily have chosen to-*

*Clare: That's what I'm saying, that's what I'm saying. The, from the housing benefit thing to the job centre thing, it, it basically, I'm surprised they don't have what shoe size are you! (laughs).*

*R: (laughs) Right, yeah.*

*Clare: It's really intrusive, I'm saying I feel so....oh, get away!*

\*\*\*\*\*

*Joseph: It's very.....it's like a factory isn't it?*

*R: Right.*

*Joseph: You go in, they churn you out, you go in, they churn you out, you know it's got all that lot there.*

Negative perceptions of bureaucratic procedure related back to eligibility assessments. As assessments used a set format for questions and these did not focus extensively on mental health, there was felt to be little opportunity to discuss

individual difficulties in this context. In large scale systems, it is arguable that standardisation is required to ensure effective information management and fairness, however, here this was felt to be at the expense of providing a meaningful assessment of need.

*Stephen: But it's all protocol isn't it, it's all written in front of them?*

*R: Yeah.*

*Stephen: They're asking you...set questions where it's irrelevant to what is actually up with you.*

*R: Yeah, yeah, so for you it would have been better if they were asking different questions about your...*

*Stephen: What's actually wrong with me yeah, not what they've got in front of them.*

\*\*\*\*\*

*Jenny: Yeah, you get shoved from pillar to post most of the time.*

*R: Do you, right, yeah.*

*Jenny: I had a doctor ring me to tell me I needed to see a doctor one time (laughs).*

Bureaucratic processes were perceived as a form of surveillance, working on the implicit assumption that without the continuous collection of information from claimants, they would act fraudulently. Surveillance was felt in a more acute sense during physical interactions.

*Peter: Er...and they were great for me, however I'd never been to the job centre before er...to go to that job centre at bottom of (place name) was like walking into a military installation.*

*R: Really?*

*Peter: The security, I und-, don't get me wrong I understand there's reasons for it and there's security guards everywhere and they march you to each department, the, the level of people there and do you know, how angry they are er..there's fights that break out in these places...you know I, I totally feel for the people that work there, absolutely.*

*R: Yeah, how did you feel going in to that then with all the security?*

*Peter: Intimidated.*

\*\*\*\*\*

*Clare: Erm, other things involved, erm....but my greatest wish is to be in that position to work again, to get, to be able to afford to..even if it's just by the skin of me teeth, just that I'm working and there's nobody on me case, on me...er, som-, you know.*

*R: Yeah.*

*Clare: Whoever's watching.*

*R: Yeah.*

*Clare: And I'm not doing anything wrong but erm.*

*R: So you, do you get a sense that you're kind of being monitored-?*

*Clare: God yeah, definitely, no two ways about it.*

*R: Yeah, yeah. So partly you'd like to get back to work for you but partly to stop this process kind of going on?*

*Clare: Yeah, yeah, definitely.*

The role of surveillance has been much discussed in the benefits system, particularly in relation to Foucauldian notions of self-policing and state policing of claimants (Manji, 2017).

### **7.2.5. Financial Circumstances**

Ultimately, all participants in the study were in receipt of income and housing benefits, with one person also in part time work. In this sample, thirteen individuals described some form of financial hardship and the range of difficulties included debt, fuel poverty, food poverty and rent arrears. Low incomes impacted on the ability of participants to become involved in community activities and maintain their social networks. Five individuals did report they found their income to be adequate with one individual stating that his financial security had actually increased since leaving work as he now had a consistent and reliable income.

### 7.2.6. Self-stigma

Self-stigma is defined as the internalising of negative stereotypes and may lead to low self-esteem (Corrigan, 2016) and shame (Goffman, 1963). As a study focusing on the stigma perceptions of people with mental illnesses, this was a key topic area during data collection and there was evidence that self-stigma was present in the sample at the intersection between mental illness and being a user of the welfare system.

*Clare: As to what I can manage, I do what I can manage, I don't beat..the first kind of six years I beat myself up a lot 'cause I wasn't well.*

*R: Okay.*

*Clare: When I first erm, went on to benefits it were kind of like (gasp), I didn't want to be back here.*

*R: Right.*

*Clare: Right, been wo-, I've been working eight years...erm, I, I really didn't want to and I'm think-, I'll have a year off, okay, a year off, get myself sorted and so then because it were longer, I beat myself all the time.*

\*\*\*\*\*

*R: Okay..so did you, did you find that helpful, meeting with that person then?*

*Sarah: No, it destroyed me because I know I couldn't go back to work.*

*R: Right.*

*Sarah: It made me depressed even more.*

*R: Right, okay.*

*Sarah: We-, it makes you feel, erm, worthless.*

Although some participants spoke explicitly of experiencing low self-esteem, the most frequent reaction in the sample was one of anger, grounded in a feeling of being misunderstood. Participants reported that although they perceived themselves as genuine claimants who were unable to work due to their health, they did not feel that others saw them this way. The awareness of being perceived negatively by others was also distressing, even where participants did not subscribe to these views about themselves, as the following interviewees report:

*Anthony: Yeah, I'm not choosing to have these problems you know, that's more to the point.*

*R: Yeah, yeah.*

*Anthony: And like I say I don't think people understand that, you know, until they've had that problem either themselves or with family or good friends or something you know, people that they know well.*

\*\*\*\*\*

*Alan: But mental health, you, there's two ways that society in my opinion, it's either you're some sort of crazy that people want to keep away from or..erm...you're, you're some sort of wastrel who's swinging the lead and, and it's society's attitudes to mental..and neither of those things are true in most people's cases.*

*R: Yeah, sure, sure.*

*Alan: Not crazy people who want to go out doing awful things and we're not people who are swinging the lead either.*

*R: Yeah, yeah.*

*Alan: You know, it's a genuine illness and I think society's attitude is in the dark ages when it comes to mental illness.*

\*\*\*\*\*

*R: So is it, is that making your self-esteem lower..is that what you mean?*

*Joseph: Well erm.....I think people presume I can't, I don't work and I'm lazy and that and it's not, it's 'cause I've got psychological, mental health issues, do you know what I mean like?*

\*\*\*\*\*

*Jane: It's not like I want to live like this, I don't want to live like this, I wish I could go out and get a job, it's horrendous dep-, erm, relying on the state because all they do is just, it's awful.*

*R: Yeah, yeah.*

*Jane: Makes you feel (becomes tearful)..sorry.*

### 7.2.7. Responsible Citizens

The perceived negative attitudes of others were directly associated with ideas of playing the system or ‘scrounging’. Participants were keen to explicitly convey their willingness to work during the interviews and to underline that their inability to work was due to poor health, constructing themselves as conscientious users of the welfare system with a genuine need.

*Sarah: .....So...but me, if I had a choice, I'd be back to work tomorrow. Benefits, it's hard to live on benefits and I think people out there don't understand how hard it is to live, from living a so-, living in a society where you've always worked, you've always provided for yourself....you've paid for everything that you've ever had.....*

*R: Yeah, yeah.*

*Sarah: And then all of a sudden, that gets stripped, and I'm saying it, it gets stripped away from you, little by little by little, like by little..nobody understands the pain, the er, the hurt, what it actually does to you.....because everybody, unfortunately I'm not like everybody else that can skip along to the social and be alright, sign on and skip away and feel like 'oh'.*

\*\*\*\*\*

*Callum: You know, up until me mental health problems started I was quite, I worked constantly from leaving school.*

*R: Yeah, yeah.*

*Callum: You know...I've always wanted to go out and earn money.*

In this way, participants presented themselves as responsible citizens who wanted to work but were unable to do so, in opposition to those who were perceived to be using benefits as a lifestyle choice. The desire to work was constructed as an innate characteristic, so that some people had an inherent work ethic, whilst others did not.

*Peter: Er...I smoke so I manage my tobacco all week do you know what I mean and I scrimp myself and scrimp myself so that me money lasts me. So it, it certainly ain't a picnic and all these people out there that have a lovely lifestyle on it and don't wanna work, I'm sorry but I'm not one of them you know what I mean.*

\*\*\*\*\*

*Jane: Yeah, I mean I come from a working family, all my family worked, well it's, mental health runs in our family you see, yeah.*

\*\*\*\*\*

*Callum: You know....I don't think mental illness is genetic you know...a lot of people say it is in your genes you know...I don't think that's true.*

*R: No...but, so for you it's different things that might-*

*Callum: Mmm, yeah...a lot of my family over the years, a lot have, they've all been...workers, grafters, you know, big family...have a lot of kids, you know and so that in turn shows me there that there's no real truth to it.*

Constructing identities to suggest an inherent desire to work appeared to be designed to counteract a sense of implicit blame. That this justification happened explicitly and unprompted may suggest that participants felt the need to counteract perceived negative opinions by emphasising their innate work ethic, that they were responsible citizens and that they had not chosen to become unwell. Responsible identities were also constructed in a relational way, through comparison with those who were felt not to be using the welfare system appropriately. Most commonly, participants compared themselves to drug and alcohol users, whose difficulties were portrayed as a lifestyle choice. Some participants saw drug and alcohol users as individuals with mental health issues like themselves but who had made a conscious decision to solve their problems using what was perceived as a negative coping strategy. In this way, a hierarchy of stigmatised identities was constructed.

*R: Yeah, yeah....so have you, so when you sort of mentioned there's some people who might need that support and then there's some people who don't want to work, are they people that you've come across then or is that-*

*Joseph: Quite a few of them I have yeah.*

*R: You have? Yeah.*

*Joseph: It's er.....well it's like you get your people who've got substance misuse and things like don't know, just not..generalising with them but you know what I mean.*



### **7.2.8. “If your bed was on fire, you’d soon move”: Perceptions of being unable to work due to mental ill health.**

One of the most prominent and consistent findings in the study was a perception that mental illness was not viewed by others as a valid reason for a person to be out of work. Although participants did not generally agree with this viewpoint themselves, it was felt to be endemic both within the social security system itself and in wider public opinion. There was a perceived inequality in the way that mental health issues were treated in this context, as compared to physical health difficulties. Consequently, individuals felt devalued and that the significant impact of their illness on everyday life and work was not recognised.

*Susan: They’re you know...and then we are a statistic in society, you know, and that’s wrong. My life is, is just as valuable, just as erm..important as the next persons, just because unfortunately you know, I have an illness....you know, and it, it’s still back to that I haven’t got a broken arm or a broken leg.*

*R: Mmm.*

*Susan: So because they can’t actually see it, it’s not stamped on me head, you know, I’m the one that’s wrong.*

\*\*\*\*\*

*Ruby: Erm.....they’re kicking people off now, of ESA because of mental health and different things, they’re not keeping you on anymore.*

*R: Okay, right.*

*Ruby: You’ve got to have erm..a pin in your back or something up with you physically.*

*R: Right.*

*Ruby: I think now for them to keep you on, mental health wise...they’re basically saying you know..you may have mental health issues but you are fit for work.*

\*\*\*\*\*

*Alan: You know, nobody’d look at somebody, you know, if you or me said “oh, I’ve got diabetes”..nobody’d look at you and think “pfft, yeah” (sarcastic tone), you know “there’s nothing wrong with you, you’ll be alright” but you know, they’d believe you but you say “I’ve got a mental health issue”....quite often people are very sceptical, I mean I’ve got a close family relative who’s a very lovely person, you*

*know, it's an aunty, and she's a very lovely kind person, you know, I love her to bits but she's no understanding of mental health issues.*

*R: Right, right.*

*Alan: Oh she went mad with me recently, "why are you off work again? Get out there, there's nothing wrong, get yourself out there".*

*R: Really?*

*Alan: Yeah and I put, put the phone down on her which I felt awful about, she said "you know, you need to get yourself out of bed" but I couldn't move Katie, I was so depressed.*

The illnesses faced by participants in this sample did not lend themselves to a traditional conception of incapacity, meaning that because individuals appeared outwardly to be physically able; their difficulties were not viewed as having the same severity and therefore preventing the person from working. Participants reported encountering this attitude in the welfare system and during interpersonal relationships.

*Ruby: You know if you go for mental health...somebody who doesn't know the situation "ah, mental, psycho" all this, that and the other. If they see somebody in a wheelchair "oh God, oh that poor person, what have they been through?". But up here I'm as disabled in my head as that person is in that wheelchair.*

*R: Yeah, yeah.*

*Ruby: You know, I am just as bad as that person....up here because I can't get myself out of this dark place and...you know, you don't get people rushing round you with mental health.*

\*\*\*\*\*

*Anthony: Yeah I feel like I, I feel like my benefits have been cut because they don't believe that it's, that it's a good enough reason, they believe I, what I believe is that I've got to be in a wheelchair to..in their eyes you know.*

*R: Yeah.*

*Anthony: I believe that in their eyes, I've got to be in a wheelchair to be eligible for that stuff, you know.*

*R: Right, so for you then having a mental health problem may not-*

*Anthony: I don't believe that they're taking it in consideration, into consideration you know.*

These ideas were associated with implicit blame, because individuals were viewed as having made a conscious choice to remain out of work, they felt that others perceived them as fraudulent or undeserving. Some individuals also subscribed to the idea themselves that large amounts of claimants were misusing the welfare system and these people were blamed for the negative attitudes of others towards benefits claimants. This is an interesting contrast, since many of the participants found their own claims process to be overly stringent.

*R: Right, so for you, are you saying then that it's been important to be involved in the mental health services?*

*Louise: Yeah, 'cause you get people what try it on as well.*

*R: Do you? Yeah, yeah.*

*Louise: Yeah, you know say "oh we've got mental health problems" and stuff like that but er, when you go and see your psychiatrist, they can diagnose you, you know, if you've got mental health problems or not or if you're lying to 'em you know.*

*R: Right, right.*

\*\*\*\*\*

*Mark: Well..they've got the upper hand at the minute, it's because of they, they're working like, doing their shifts nine 'til five every single day and...they're putting in the big pot and where everybody else is not working, it's like they, they're working their arse off all day long for all the ones that are not working...but..all they're seeing are the ones that are not working...going around the city all day, in the shops, spending like nothing's going on, they're not actually ill, this that or the other.*

\*\*\*\*\*

*R: Okay..and so you're saying that there might be this idea that people are sort of playing the system.*

*Jane: Mmm...and it makes it harder for them who's genuine, do you know.*

*R: Yeah, yeah...do you think that's a big problem then, people playing the system?*

*Jane: Yeah, yeah, I do, they should....I do yeah, I mean it's easy for anybody to say they've got depression these days.*

### 7.2.9. The role of political and media narratives

Participants felt that media reporting on mental health had generally improved over time and had contributed positively to raising awareness, for example, through the involvement of celebrities such as Stephen Fry and Ruby Wax. In the context of reporting on mental health in the welfare system, however, the media was perceived as perpetuating ideas of fraud and blame. Five participants discussed programmes such as 'Benefits Street' which take a documentary format and follow the everyday lives of people using benefits. Some participants viewed this type of coverage as providing evidence that fraud was endemic within the benefits system whereas others viewed this as publicity designed to further a political objective of withdrawing entitlement to social security.

*Alan: That's right, in a nice way, yeah, yeah so that's what I try and do but yeah, you hear people, yeah you know like, as I say it's mainly this horrible TV like er, Benefits Street and all the rest of these, erm, they're the ones that erm..perpetuate this narrative.*

*R: Right.*

*Alan: And, and eventually, people say "ah yeah but it's only a bit of telly" you know but eventually that trickles down to the populous and, and then you know, that formulates policy eventually.*

*R: Right.*

*Alan: And, and you know because they'll say "oh well we're going to stop providing this and people are abusing this and people are abusing the other" and, and they're not, they're not...what they're doing is...they're creating the narrative in the public's mind and the public, you know, it's like you know when they say "oh, there's all these immigrants taking our jobs", well no they're not.*

\*\*\*\*\*

*Anthony: There's all sorts, there's Living on Benefits, Benefit Street, all sorts of these programmes now and it's just making people look lazy, I mean yeah there is a lot of them that are lazy you can blatantly tell that but there's...there'll be some of them people that, poor sods in them videos, documentaries and stuff like that or them, these channels and things that are actually, have got problems and stuff like that but because they've got theirself filmed on TV doing these documentaries, they're looked down on because of the other people that are just idiots that they film, you know what I mean, they go looking for an idiot literally to do it on purpose and make people that are on benefits look like...wasters.*

*R: Right.*

*Anthony: To make it so that...I believe it's been done on purpose to help cut benefits, you know what I mean...definitely.*

\*\*\*\*\*

*Jane: Yeah and the media's just giving them money to film and do you know and ripping off the benefits system and then it makes us look bad, people what suffer from mental health it makes us look like idiots.*

The media was therefore viewed by some participants as a tool to further political objectives with the aim of gaining public support for reducing the number of benefit claimants through narratives of fraud, misuse of the system and dependency. Opinions on the extent to which these narratives are purely ideological or whether they are reflective of a need to optimise limited financial resources were mixed in the sample, however, there was an overriding view that benefits for people with mental illness are being intentionally reduced. This extended to a perception that mental health services more generally were underfunded as compared to other healthcare. This is interesting given that there has been an active drive to deliver parity of esteem in recent years and that this commitment has been enshrined in law since the introduction of the new Health and Social Care Act in 2012 (The King's Fund, 2017).

*Alan: You know, and, and unfortunately, I mean I don't want to get too political but you know, we've, we've, you know I don't think the Government help things when they, you know, they're not...they don't take mental health seriously, you know and their programmes are..*

*R: That's really interesting to hear that, what makes you say that, what makes you think that?*

*Alan: Well, as I say just recently if you've sort of seen any things in the media they've, they've erm, when people are, there was a Tory minister who came out and he, he said something like erm, "oh, why are we paying erm, er personal independence payments to people who are just sat at home taking pills for their anxiety".*

Here Alan was referring to comments made by George Freeman, Conservative MP and head of the No.10 Policy Unit in February 2017 following a legal challenge to changes introduced in relation to Personal Independence Payments:

*“These tweaks are actually about rolling back some bizarre decisions by tribunals that now mean benefits are being given to people who are taking pills at home, who suffer from anxiety. We want to make sure we get the money to the really disabled people who need it”.*

These comments were widely criticised in the public arena, however, here they have had a lasting impact on how policy makers are perceived.

*Sarah: Because I think the way things are changing and how they are, if they could bleed, get blood out of a stone, ‘cause they’re attacking, they’re attacking me.*

*R: Right.*

*Sarah: Government are attacking me.*

*R: Right.*

*Sarah: Because of me disabilities.*

\*\*\*\*\*

*Mark: Yeah so I just think it’s them controlling it, making peoples’ lives a mess, do you know, with their benefits, this that and the other, making them (...). I just always thought that were Government...like...yeah, they’re on their high horse watching everybody run around like little mice trying to sort out their lives and that and then they’re like pressing a button (imitates pressing and makes accompanying noise)*

It is not possible in this study to assess whether benefits for people with mental health issues are being intentionally reduced but this perception has the potential to be damaging for claimants in terms of stigma and could contribute to underclaiming.

### **7.3. Discussion**

Overall in this sample, experiences of accessing health related income benefits were mixed. For some participants, the process of assessment through to receipt and maintenance of financial support ran smoothly. A key factor here appeared to be the input of healthcare professionals, who submitted additional evidence for claims and attended assessments to provide support. For eleven out of eighteen participants however, the process was fraught with difficulty and individuals disagreed with the decisions made in relation to their financial support. It was not possible in this study to assess baseline level of need, however a significant number of decisions were later overturned or successfully appealed, which does suggest that some elements of the process were problematic.

Eligibility assessments are designed to act as a standalone method of determining level of need using an objective and predetermined points based scoring system. Theoretically, this should work well for people with mental illnesses, since only a comparatively small number of people are in regular contact with secondary mental health services and therefore have access to supporting evidence from a specialist healthcare professional. However, in reality the majority of participants felt that their needs were not appropriately assessed and they were left having to recount difficult or traumatic experiences in order to provide proof of illness. Regardless of whether the eligibility assessment had a positive outcome, the anticipation and interview itself were a significant source of stress and anxiety for most participants in the sample. Similar findings are reported by Barr et al. (2015b) who attributed an excess of 590 suicides, 279,000 cases of self-reported mental health problems and 725,000 anti-depressant prescriptions to the re-assessment of benefit claims between 2010 and 2013. This does not include the more recent transition from Disability Living Allowance to Personal Independence Payments so these numbers may now be higher.

In addition, the assessment process was overwhelmingly felt to focus on physical health rather than exploring the impact of mental health on activities of daily living. Mental illness was usually described as having an indirect effect, for example, although a person could wash and dress or eat independently, they may not have the motivation or energy to do so and this was no less debilitating than being physically unable to put on an item of clothing. This distinction was not felt to be recognised by

assessors or by the assessment questionnaire itself. The potential for such difficulties to arise has been noted by commentators but evidence has only emerged more recently. In support of the findings of this study, research on welfare conditionality conducted by Dwyer et al. (2016) found that claimants with a mental illness felt their difficulties were disregarded during the ESA claims process. Both this study and the current findings use qualitative interviews and so represent individual perceptions of eligibility assessments, however, it is notable that the studies took place independently and in different areas of the UK.

Ultimately, all participants in the sample did receive some form of financial support, albeit with different conditions attached depending on the benefit type. Yet for most, the lived experience of social security was permeated by fear and insecurity. A key driver here was the underlying conditionality present in the system which acted as a form of financial control, since monetary support could be withdrawn at any time through the application of sanctions. If a sanction is administered payments may be stopped for up to four weeks (ESA) or three years (JSA) depending on the reason (Gov.uk, 2018). Payments are also stopped if a person does not attend an eligibility assessment at any time. Evidence on the impact of conditionality is still emerging because the increase in its application is relatively recent; however current evidence does suggest that people with mental illnesses are more likely to be subject to sanctions than other claimant groups and that conditionality is not effective in moving claimants towards work (Joint Public Issues Team, 2015; Dwyer et al, 2018).

This evidence suggests that the concerns of participants may be well-founded, but within the sample very few individuals had actually been subject to a sanction. Instead, it was the fear of sanctions that enabled conditionality to secure compliance. The constant threat of losing financial support was highly stressful for participants, leading three individuals to express thoughts of suicide. Although arguably there is a need for claimants to meet certain requirements to ensure benefits are being administered correctly, ultimately conditionality has a detrimental impact on mental health, perhaps further delaying recovery. Conditionality extended beyond sanctions for those already in receipt of benefits to the assessment process. Here participants reported that receiving financial support was contingent on the disclosure of information they did not feel comfortable discussing, such as traumatic events that



had contributed to the development of their illness. Shefer et al. (2016) reports the same findings in a study of claimants with mental illness who were going through the appeals process.

Life on the income provided by benefit payments was difficult for almost all of the participants, contrary to what was perceived as a popular belief that claimants live a comfortable or even lavish lifestyle. Individuals were unable to do much more than buy food and pay their bills each month although even this was not always possible. Food and fuel poverty, and debt were all experiences described by participants in relation to reliance on state financial support. Participants were keen to make explicit the difficulties they faced and to dispel the myth of high social security incomes, frequently describing their experience as existing rather than living. This holds significant implications for social exclusion, exacerbating the longstanding difficulties already faced by people with mental illness.

Although broadly, attitudes towards people with mental illness were felt to be improving, this was not the case in the context of claiming health-related income benefits. Participants reported direct negative effects on self-esteem, indicative of self-stigma, however, the most common reaction was a feeling of being misunderstood. Whilst individuals felt that they were perceived negatively by others, they did not usually subscribe to these views themselves. A key component of self-stigma is the internalising of negative attitudes but here instead the reaction was one of anger and injustice. This type of reaction is not incorporated into traditional definitions of the self-stigma associated with mental illness, however research on shame suggests the two may be linked. Gilbert and Miles (2002) suggest that anger can be a reaction to feelings of shame which arise because the self is threatened. Since shame is closely linked to self-stigma (Thornicroft, 2006), it is possible that this finding represents another form of self-stigma because the integrity of the person is threatened here by accusations of fraud and dependency.

An alternative explanation is that the anger and injustice expressed is a reflection of increased awareness around mental health and effective anti-stigma initiatives, which have led to a reduced sense of blame and increased empowerment, however, there are several factors suggesting this is not the case. Firstly, public attitudes in this context continue to be stigmatising according to the perception of participants.

Whilst it is not possible in the current study to test actual public attitudes, multiple participants recounted incidents in which the validity of their illness had been challenged by a family member or the wider public, which is not suggestive of a reduction in stigma. Secondly, participants were subject to coercion within the system and were unable to change their situation, which does not indicate increased empowerment.

### **Dependency or Entitlement?**

The findings from this study add evidence to the idea that welfare dependency as a dominant narrative can be harmful and stigmatising for individuals with a disability (Garthwaite, 2011). Notions of a ‘dependency culture’ centred on generations of worklessness are much cited in the media and in current political thinking, although a study which aimed to find families with intergenerational worklessness found strikingly little evidence of its existence (Shildrick et al., 2012). Nevertheless, this narrative was clearly present in the study through essentialist ideas of an inherent work ethic and participants justified their own need to claim benefits within these parameters. Although the role of the media and politicians in perpetuating this narrative was discussed some of the time, most frequently, it was other claimants who were perceived as causing negative public attitudes by misusing the system.

Baumberg (2016) describes dependency narratives as functional, since creating stigma in a system where benefits are not universally provided helps to discourage some potential claimants, therefore reducing pressure on resources. A stated aim, for example, of the introduction of PIP as a replacement for DLA was to cut costs (Fullfact, 2017). Although the stigmatising of people unable to work due to health reasons is arguably always problematic, it is especially so when the impact of the illness itself is poorly understood by policy makers and the public, as appears to be the case with mental health conditions.

That welfare benefits should be restricted unless certain requirements are met represents a shift away from unconditional social rights that have historically been foundational to ideas of citizenship (Dwyer, 2017). This extension of conditional entitlement to people with long term health conditions and disabilities represents a ‘rewriting of the social contract’ because it is a shift away from ‘de-commodified’

social rights (Dwyer, 2017) and towards a model in which there is an expectation that individuals should contribute through employment if they wish to maintain their access to social security.

As indicated in Table 12, almost all participants in the study had been previously employed, often with a longstanding mental illness, prior to their current difficulties. Welfare dependency narratives here were not only inaccurate, but also created a sense of shame amongst participants because the need to access financial support through the welfare system due to ill-health was no longer viewed as a right of citizenship.

| Participant     | Previous Education/Employment |
|-----------------|-------------------------------|
| <b>Sarah</b>    | Receptionist                  |
| <b>Margaret</b> | Administrator                 |
| <b>Thomas</b>   | Shop assistant                |
| <b>Robert</b>   | Civil servant                 |
| <b>Joseph</b>   | Construction worker           |
| <b>Clare</b>    | Family outreach worker        |
| <b>Ruby</b>     | Self-employed                 |
| <b>Callum</b>   | City council worker           |
| <b>Louise</b>   | Cleaner                       |
| <b>David</b>    | Electrician                   |
| <b>Peter</b>    | Call centre manager           |
| <b>Stephen</b>  | Lifeguard                     |
| <b>Mark</b>     | Not known                     |
| <b>Jane</b>     | Unpaid carer role             |
| <b>Anthony</b>  | Art college                   |
| <b>Alan</b>     | Support worker (Current)      |
| <b>Susan</b>    | Support worker (voluntary)    |
| <b>Jenny</b>    | Painter and decorator         |

Table 12. Employment history of interviewees

### **Power, disempowerment and citizenship**

Power was central to the experiences of participants in the study, generated through financial control. Financial power was manifested overtly in conditionality and eligibility processes but most often covertly, by producing a fear that monetary support would be withdrawn. Although it might be argued that there is a need to ensure claimants are accessing benefits appropriately, the constant anxiety and stress

surrounding the use of state financial support here is not conducive to recovery from mental illness.

As participants were unable to work due to their health, they were also unable to change their reliance on state financial support, meaning that a feeling of coercion was a pervasive part of their experience. The power differential produced by financial reliance led many participants to act submissively, believing that monetary support could only be maintained through politeness and full compliance, even where they disagreed with decisions. Although the role of conditionality and surveillance in the welfare system has been discussed in the literature, there has been less focus on the implications for disempowerment.

Disempowerment in this context is especially salient for people with mental health conditions because of the historical role of power and coercion in psychiatry (Foucault, 1967). People with mental illnesses still today remain one of the only groups of healthcare users who can be treated without their consent and subjected to a range of controls in both hospital and the community because of their illness (Mental Health Act 1983/2007). Power is further implicated in experiences of stigma, acting to maintain the marginalisation of certain devalued groups by upholding the social structures that enable exclusion to take place (Link and Phelan, 2001). Social orders are maintained by the powerful through the use of language that promotes division (Bourdieu, 1991). This is most effective when ideas of a natural or 'common sense' order are evoked:

“The distinctions that are the most efficacious socially are those which give the appearance of being based on objective differences” (p120).

Intentionally or otherwise, narratives of dependency coupled with the idea that mental illness is not a valid reason for being out of work may produce increased stigma. The suggestion that some members of society simply do not want to work because it is not in their nature to do so acts to justify paternalistic interventions, in which individuals must be coerced into employment because they would otherwise actively avoid this. Where the person has an invisible condition that does not fit the traditional image of a disabled person, the individual may also be held personally responsible for their difficulties and accused of misusing the system. In this study,

thirteen out of eighteen participants reported feeling that they were implicitly blamed for their own situation.

Achieving full citizenship has always been a difficult path for people with mental illness. Against a background of incarceration and control, human rights have not been automatic. In more recent decades, a move towards community inclusion has created an increased drive to promote rights and equal citizenship, however policy makers have sought to integrate rights with 'responsibilities', leading to increased conditionality and therefore perpetuating this underlying authoritarianism (Carpenter, 2009). Inequality in the provision of services and treatment of people who require health related income benefits due to mental illness further impedes the realisation of equal citizenship not only because it exacerbates existing poverty and marginalisation but because individuals remain disempowered in this context.

### **Parity of Esteem**

Underlying the key narrative of entitlement versus dependency are the reports of participants that their mental health was not viewed as a valid reason to be unemployed. This was felt to be an inherent assumption within the welfare system, based on the perception that assessment processes were focused on physical capability and the effects of mental health symptoms on functioning were not felt to be recognised.

Validity featured not only in the welfare system itself, but during interpersonal interactions in which participants described their symptoms as being perceived as less severe than physical health conditions. In part, this was associated with the invisibility of mental health conditions however some physical health conditions are also not immediately visible, for example, epilepsy. From data in the interview study, this lack of recognition of the role of mental illness in preventing individuals from being able to work could be associated with notions of 'capability'. Participants felt that their condition was not recognised in this context because mental illness is not associated with traditional representations of disability, for example, several participants gave the example of a wheelchair user receiving sympathy from others, contrasting with their own experiences of rejection. Dismissing or misunderstanding health conditions in this way can act as a discrediting experience for the unwell

person (Charmaz, 1991) and in this way may lead to social exclusion (Goffman, 1963).

Notions of validity were intimately associated here with fraud and deservingness. This means that individuals with mental illnesses could be acutely affected by such narratives because of the underlying assumptions about validity. Parity of esteem, defined as 'valuing mental health equally with physical health' has been widely discussed in relation to health care and recently enshrined in law to ensure a fair distribution of resources (Mental Health Foundation, 2018). This guarantee of equality may need to be extended further to incorporate other public institutions.

### **Mental health, work and the recovery model**

A clear finding in the study was that individuals in the sample did want to work but felt unable to do so for health reasons, contrary to the perceptions of others that they were overestimating the severity of their illness. There has been a drive in recent years to ensure that more people with mental health problems are able to access employment and recognition of the barriers that may prevent them from doing so, in line with the recovery model (Repper, 2003).

The recent shift in eligibility criteria towards a focus on functional assessments is in line with a recovery focused approach. Disability activists have argued, however, that a framework designed to encourage people to think positively about disability has been misappropriated by policy makers and used as a method of coercing more disabled individuals back into work (Cross, 2013). With functional approaches, there is a danger that blame for being out of work due to ill health may fall on the individual, because of the implication that symptoms of illness are no longer a barrier to recovery and therefore employment.

### **Limitations**

The key limitation of this study relates to the generalisability of these findings to the broader welfare reform context because the experiences described by participants relate to one particular research location. Although Leeds is a large city, all residents attend two main assessment centres in order to access health-related income benefits,

meaning that difficulties encountered particularly during eligibility assessments could be a function of these individual assessment centres, rather than being reflective of a broader systemic issue. A further limitation is that of the sampling technique used in the study. A reliance on support staff as an intermediary during recruitment has the potential to introduce bias, since it is not possible to know entirely how or why particular interviewees were selected.

At the interviewee level, although questions were kept open with an emphasis on both positive and negative experiences, it is possible that recall bias could have affected responses. If, for example, a person had received an unsuccessful outcome at their last assessment, this could encourage negative perceptions of the entire process. Associated with this, it is important to remember that the findings reported here are based on individual perception and do not represent an objective assessment of individual level of need at the time the person decided to attempt to access financial support. This means it is possible, for example, that not awarding a particular benefit was the correct decision in terms of the health status of the person.

Ultimately, the limitations described here focus on the subjective nature of studying individual perceptions. Arguably it is not the function of this type of research to be generalisable beyond the context in which it is situated, given that the focus is on individual lived experience. This does, however, prove problematic if the research is to be used as evidence to recommend improvements to current systems and practices. Nevertheless though, the weight of the evidence is increasing over time more broadly and it is for this reason that further research on these topic areas is required.

## **7.4. Conclusion**

This study has explored the lived experiences of people with mental illnesses who are accessing financial support through the welfare system. It has found that whilst outcomes were both positive and negative for claimants in the sample in terms of receiving financial support, the experience of attending eligibility assessments and more broadly of being a welfare system user was characterised by stress, anxiety and disempowerment. This was further compounded by the associating of mental illness with existing welfare dependency narratives, which promoted the idea that mental illness is not a valid reason for unemployment. This was a devaluing experience for participants, leading primarily to reactions of anger and shame. The majority of interviewees in the study reported that their experience of relying on social security as a main source of income had also caused poverty and social exclusion. As such, this study has demonstrated that socioeconomic factors at the micro level, in terms of individual experiences of accessing social security, and at the macro level, in relation to the impact of recent reforms on increased conditionality and changes to eligibility assessments, are associated with the stigma experienced by people with mental illnesses in the post-2007 recession context.



# **Chapter 8: Systemic factors and individual disadvantage: The case of extra-cost disability benefit reform**

## **8.1. Introduction**

This chapter focuses on two key hypotheses in relation to the outcomes of claimants with mental illnesses undergoing reassessment for extra-cost disability benefits (migration from DLA to PIP), as compared to those with other health conditions. This chapter will outline the findings in relation to each of these hypotheses, beginning with a discussion on overall financial outcomes, followed by an exploration of the eligibility assessment context. It will also report on a further analysis of outcomes from the eligibility reassessment process, undertaken to further explore the findings from the analysis relating to hypothesis B. The hypotheses are as follows:

### **Hypothesis A**

H<sub>0</sub>: There is no difference in financial disadvantage following reassessment for Personal Independence Payments for claimants with a mental illness compared to those with other health conditions.

H<sub>1</sub>: There is a financial disadvantage following reassessment for Personal Independence Payments for claimants with a mental illness compared to those with other health conditions.

### **Hypothesis B**

H<sub>0</sub>: There is no difference in the number of individuals with a mental illness who have their claim for Personal Independence Payments disallowed following an eligibility assessment compared to those with other health conditions.

H<sub>1</sub>: There is a difference in the number of individuals with a mental illness who have their claim for Personal Independence Payments disallowed following an eligibility assessment compared to those with other health conditions.

## 8.2. Findings

Claimants with a psychiatric condition total around a third (28.9%) of all those reassessed from an existing DLA claim for PIP between April 2013 and October 2016 whilst representing six out of the thirty-eight health conditions included in the sample (Table 13).

| Main Disabling Condition    | No. of claimants reassessed | % of total claimants |
|-----------------------------|-----------------------------|----------------------|
| Psychiatric Condition       | 148,700                     | 28.9                 |
| All other health conditions | 365,000                     | 71.1                 |
| Total                       | 513,700                     | 100                  |

Table 13. Descriptive statistics for main disabling condition

### 8.2.1. Hypothesis A: Comparing financial disadvantage between psychiatric and non-psychiatric conditions following reassessment from DLA to PIP.

In the first instance, the level of total financial disadvantage – the number of claims reduced or disallowed, were plotted across individual health conditions to assess distribution of the data. Figure 6 represents disadvantage as a proportion of all outcomes (%) for each health condition and Figure 7 shows the same proportion as count data for the number of claimants experiencing a negative outcome.

Figure 6 demonstrates that claimants across the range of health conditions included in this sample were financially disadvantaged by their transfer from DLA to PIP. For all conditions aside from individuals experiencing severe mental impairment, dementia and paraplegia/tetraplegia, at least 20% of claims were reduced or disallowed following reassessment. In 21 out of 38 health conditions, the amount rises to 50% or more meaning that at least half of the claimants experiencing these health conditions were disadvantaged by moving to PIP, compared to their previous DLA award.

Although arguably, advances in treatment over time could create less need for financial support in some clinical populations, it is worth noting that some of the conditions where disadvantage is evident are lifelong, degenerative illnesses, for example, Parkinson's disease. Claimants with a psychiatric condition are

consistently at the higher end of financial disadvantage in this sample, with the proportion of claims reduced or disallowed ranging from 49-62% depending on the specific illness.

Figure 7 represents count data for the number of claimants with each health condition who have had their payments reduced or withdrawn after transferring from DLA to PIP. Here it is evident that whilst the proportion of claimants who are financially disadvantaged is relatively similar across the included health conditions, there is a large disparity in the actual number of individuals affected and greater numbers of individuals with some mental health conditions are disadvantaged by this process. In particular, 25,823 claimants with a mood or anxiety disorder and 41,667 claimants with psychosis have had their benefits reduced or withdrawn when transferring from DLA to PIP. Other psychiatric conditions such as ADHD have comparable numbers of claims reduced or withdrawn to those with other health conditions in the sample and some non-psychiatric conditions such as arthritis also display high numbers of claimants who have been financial disadvantaged. The graph does demonstrate, however, that a large number of people experiencing mental illnesses are now living with less financial support than they previously had access to.

## Proportion of claims reduced or disallowed following reassessment from DLA to PIP by main disabling condition

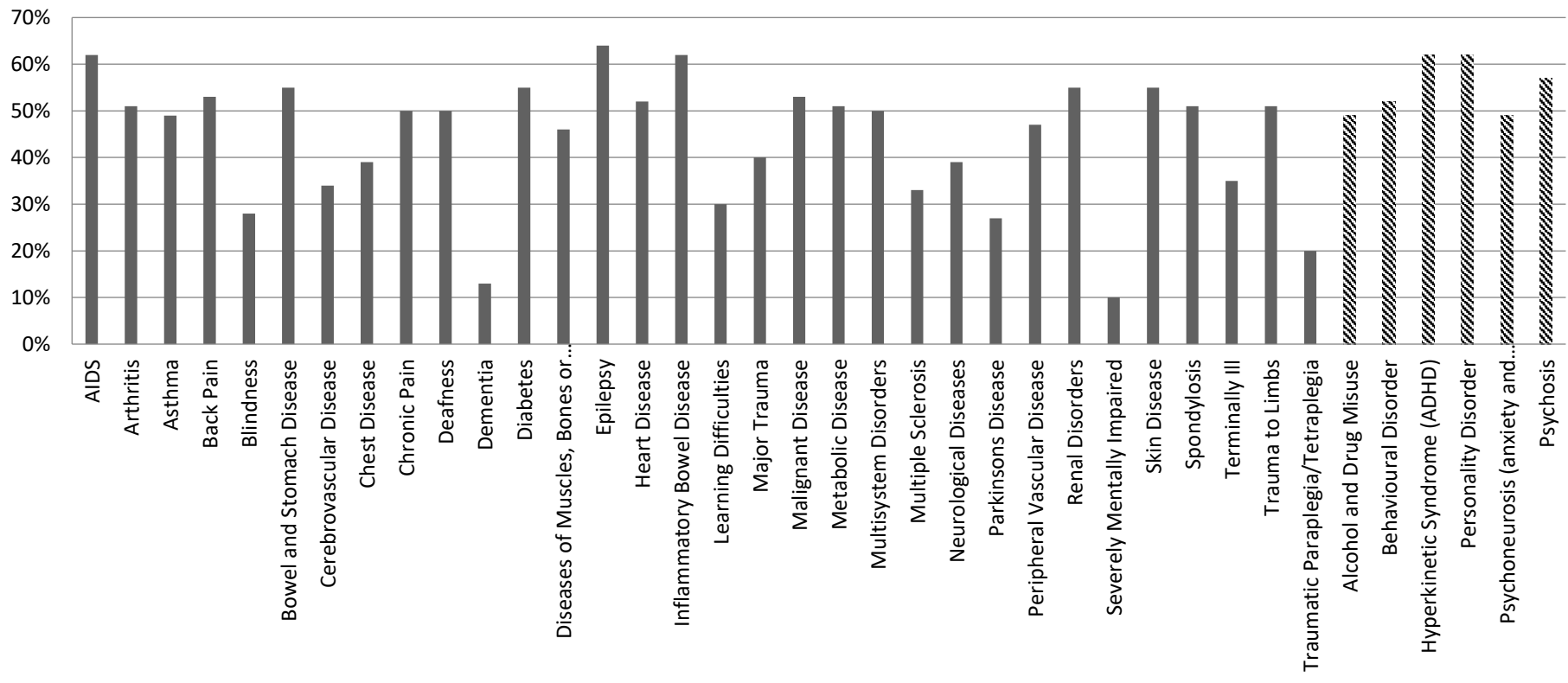


Figure 6. Proportion of claims with a negative outcome (claim reduced or disallowed) following reassessment from DLA to PIP. Psychiatric conditions included in the sample are indicated using hatchings

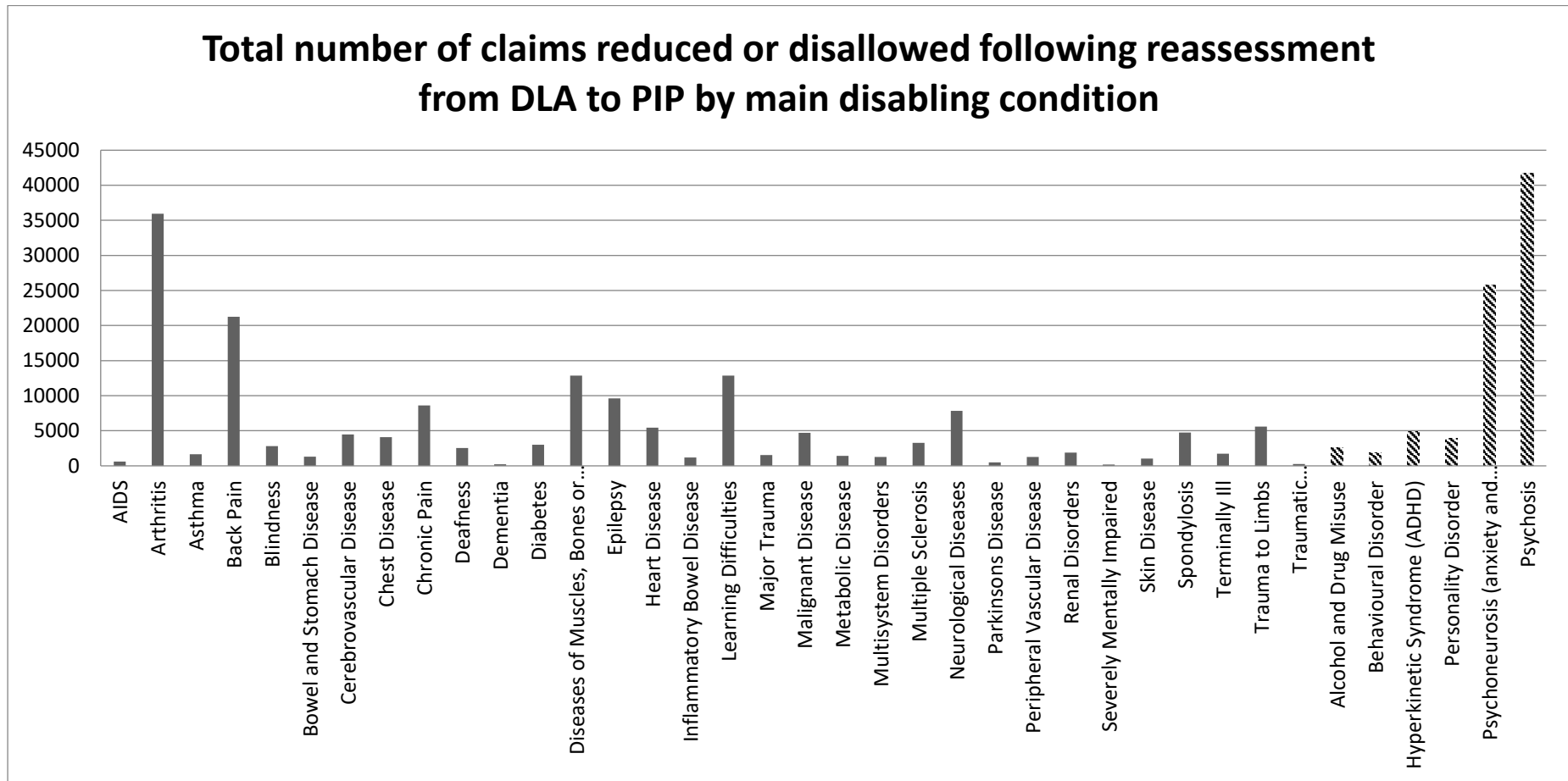


Figure 7. Count data for claims with a negative outcome (claim reduced or disallowed) following reassessment from DLA to PIP. Psychiatric conditions included in the sample are indicated using hatchings.

### Hypothesis A: Analysis

The analysis indicates that overall, individuals with a mental illness are around 1.42 (95% CI: 1.40, 1.44) times more likely to be financially disadvantaged by a reassessment from DLA to PIP compared to those with non-psychiatric health conditions (Table 14).

| <b>Mental Illness</b>                              | <b>OR</b> | <b>Confidence Interval (95%)</b> | <b>P Value</b> |
|--|-----------|----------------------------------|----------------|
| <b>All psychiatric conditions</b>                  | 1.42      | 1.40 – 1.44                      | <0.001         |
| <b>Psychosis</b>                                   | 1.59      | 1.57 – 1.62                      | <0.001         |
| <b>Personality disorder</b>                        | 1.96      | 1.86 – 2.06                      | <0.001         |
| <b>Psychoneurosis (anxiety and mood disorders)</b> | 1.15      | 1.13 – 1.17                      | <0.001         |
| <b>Behavioural disorder</b>                        | 1.30      | 1.22 – 1.39                      | <0.001         |
| <b>Alcohol and drug use</b>                        | 1.15      | 1.09 – 1.22                      | <0.001         |
| <b>Hyperkinetic syndrome (ADHD)</b>                | 1.96      | 1.87 – 2.05                      | <0.001         |

Table 14. Odds ratios for claims reduced and disallowed by psychiatric compared to non-psychiatric conditions

When odds ratios are calculated for each type of mental illness, there are clear differences between these and non-psychiatric conditions, with variations in comparative disadvantage depending on the illness. Individuals with anxiety or mood disorders are around 1.15 (1.09, 1.22) times more likely to experience financial disadvantage compared to claimants with non-psychiatric conditions and claimants with psychosis are 1.59 (1.57, 1.62) times more likely. Individuals with a personality disorder or ADHD are around twice as likely to experience financial disadvantage compared to a person with a non-psychiatric condition. The null hypothesis that there is no difference in financial disadvantage following reassessment from DLA to PIP for claimants with a mental illness compared to those with other health conditions can be rejected.

### **8.2.2. Hypothesis B: Assessing whether there is a difference in the number of claims disallowed following an eligibility assessment for psychiatric relative to non-psychiatric conditions.**

In the first instance, graphs were created (Figures 8 and 9) to depict the distribution of all individuals whose claim was disallowed following an eligibility assessment, by each health condition.

Figure 8 demonstrates that the proportion of claims disallowed after attending an eligibility assessment varies substantially across the different health conditions, however, claimants with mental illness are consistently at the higher end with 28-40% of claims disallowed in this way. On average, 32.5% of claims for psychiatric conditions were disallowed following an eligibility assessment. Figure 9 represents the accompanying count data for all claimants where PIP was disallowed following an eligibility assessment and here it is clear that large numbers of claimants with mental illness are affected – between 2013 and 2016, 17,391 individuals with anxiety or a mood disorder and 22,661 individuals with psychosis had their financial support removed after attending a PIP eligibility assessment, despite having previously been in receipt of DLA.



### Proportion of claims disallowed following reassessment of eligibility from DLA to PIP by main disabling condition

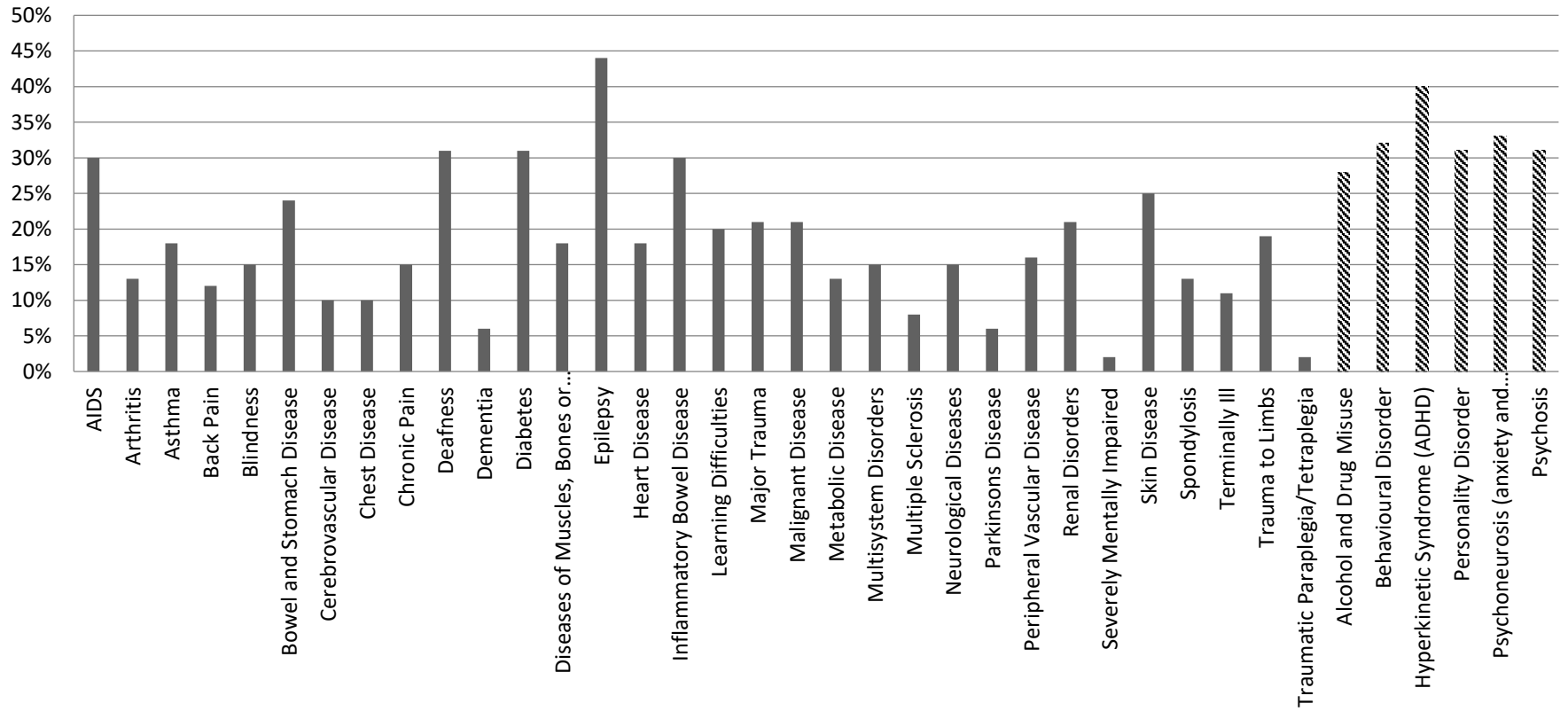


Figure 8. Proportion of claims disallowed following eligibility reassessment from DLA to PIP by main disabling condition. Psychiatric conditions included in the sample are indicated using hatchings.

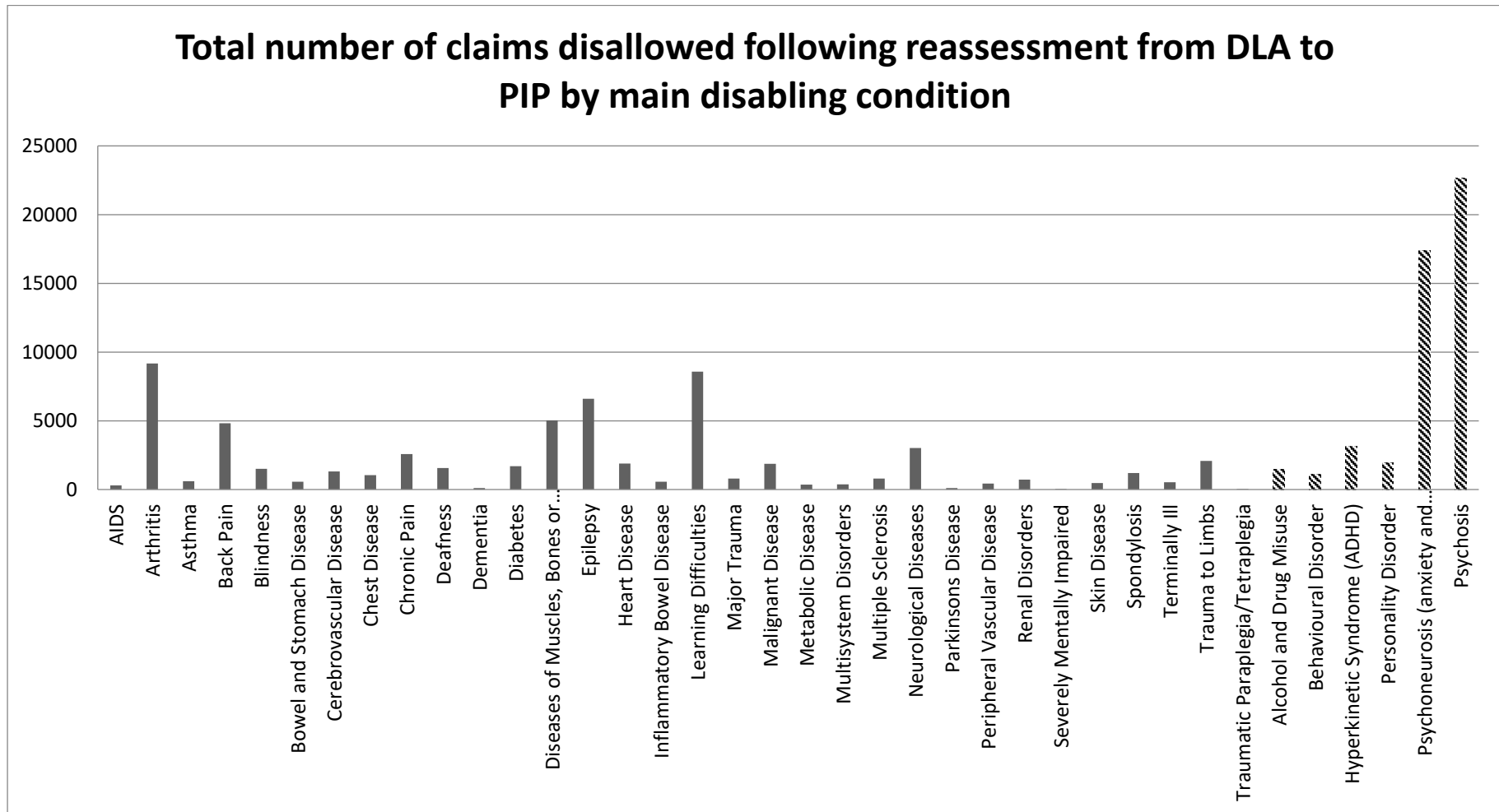


Figure 9. Total number of claims disallowed following eligibility reassessment from DLA to PIP by main disabling condition. Psychiatric conditions included in the sample are indicated using hatchings.

## Hypothesis B: Analysis

The analysis demonstrates that overall, individuals with a psychiatric condition are 2.36 (2.33, 2.39) times more likely than those with a non-psychiatric condition to lose their original DLA award following an eligibility assessment for PIP (Table 15). Claimants with psychosis are 2.24 (2.20, 2.28) times more likely to have their claim disallowed following an eligibility assessment, with similar rates for people with personality disorders, and claimants with common mental disorders are 2.46 (2.41, 2.51) times more likely compared to claimants with non-psychiatric conditions. Claimants with ADHD are 3.33 (3.18, 3.49) times more likely to have their existing entitlement removed in this way.

| <b>Mental Illness</b>                              | <b>OR</b> | <b>Confidence Interval (95%)</b> | <b>P Value</b> |
|--|-----------|----------------------------------|----------------|
| <b>All psychiatric conditions</b>                  | 2.36      | 2.33 – 2.39                      | <0.001         |
| <b>Psychosis</b>                                   | 2.24      | 2.20 – 2.28                      | <0.001         |
| <b>Personality disorder</b>                        | 2.24      | 2.12 – 2.37                      | <0.001         |
| <b>Psychoneurosis (anxiety and mood disorders)</b> | 2.46      | 2.41 – 2.51                      | <0.001         |
| <b>Behavioural disorder</b>                        | 2.35      | 2.18 – 2.52                      | <0.001         |
| <b>Alcohol and drug use</b>                        | 1.94      | 1.82 – 2.06                      | <0.001         |
| <b>Hyperkinetic syndrome (ADHD)</b>                | 3.33      | 3.18 – 3.49                      | <0.001         |

Table 15. Odds ratios for claims disallowed following eligibility reassessment by psychiatric compared to non-psychiatric condition

These findings suggest that claimants with mental illnesses are significantly more likely to have their financial support removed after attending an eligibility assessment than people with non-psychiatric conditions and therefore the null hypothesis that there is no difference between claimant groups can be rejected.

### 8.2.3. Further Analysis: Mental illness compared to chronic, relapsing and invisible conditions

Approximately 148,700 claimants reporting a psychiatric condition and 178,300 claimants with a non-psychiatric condition were included in this analysis. Thirty-two per cent (n=47,741) of claimants with psychiatric conditions lost their existing financial entitlement following a PIP eligibility assessment compared to 16.4% (n=29,323) of those in the three comparator categories (Table 16, highlighted in bold). ‘All non-psychiatric conditions’ for the purposes of this analysis refers to the three comparator categories only, ‘psychiatric conditions’ incorporates the same conditions as in previous analyses. The selection of each of the non-psychiatric comparator conditions for the purposes of this analysis is discussed further in Chapter 5 and descriptions of the conditions included in each comparator are available in the notes for the results table (Table 17) associated with this analysis.

| <b>Health condition</b>                     | <b>Claim disallowed following eligibility assessment (%)</b> | <b>All other reassessment outcomes (%)</b> | <b>Total number of claimants</b> |
|---|--|--|----------------------------------|
| <b>All psychiatric conditions</b>           | <b>47,741 (32.1)</b>   | <b>100,959 (67.9)</b>                      | <b>148,700</b>                   |
| Psychosis                                   | 22,661 (31.0)  | 50,439 (69.0)                              | 73,100                           |
| Personality Disorder                        | 1,953 (31.0)   | 4,347 (69.0)                               | 6,300                            |
| Psychoneurosis (anxiety and mood disorders) | 17,391 (33.0)  | 35,309 (67.0)                              | 52,700                           |
| Behavioural disorders                       | 1,120 (32.0)   | 2,380 (68.0)                               | 3,500                            |
| Alcohol and drug use                        | 1,456 (28.0)   | 3,744 (72.0)                               | 5,200                            |
| Hyperkinetic syndrome (ADHD)                | 3,160 (40.0)   | 4,740 (60.0)                               | 7,900                            |
| <b>All non-psychiatric conditions</b>       | <b>29,323 (16.4)</b>   | <b>148,977 (83.6)</b>                      | <b>178,300</b>                   |
| Musculoskeletal conditions                  | 20,226 (13.6)  | 127,674 (86.4)                             | 147,900                          |
| Neurological conditions                     | 7,392 (29.6)   | 17,508 (70.4)                              | 24,900                           |
| Diabetes Mellitus                           | 1,705 (31.0)   | 3,795 (69.0)                               | 5,500                            |

Table 16. Further analysis: Descriptive statistics

Overall, claimants with a psychiatric condition were 2.40 (2.36, 2.44) times more likely than a claimant with a non-psychiatric condition to have their existing DLA entitlement removed following a PIP eligibility assessment (Table 17). This ranged from 1.97 (1.85, 2.10) times more likely for claims based on alcohol and drug use, to 3.38 (3.23, 3.55) times more likely for claimants with ADHD.

Claimants with anxiety or depression were more likely to have their claim disallowed than claimants with any of the non-psychiatric conditions included in the analysis; ranging from 1.09 (1.03, 1.16) times more likely compared to people with diabetes to 3.10 (3.03, 3.18) times more likely compared to people with musculoskeletal conditions.

Claimants with personality disorder or psychosis were more likely to have their claims disallowed compared with all other non-psychiatric groups except people with diabetes, against whom they were just as likely to have their claims disallowed.

The likelihood of having a claim disallowed for claimants with a behavioural disorder ranged between 1.11 (1.03, 1.20) compared to claimants with neurological conditions and 2.97 (2.76, 3.19) for claimants with musculoskeletal conditions. Individuals citing alcohol and drug use as the main reason for their claim were less likely than claimants with neurological conditions to have their claim disallowed (0.92; 0.86, 0.98) but more likely than those with musculoskeletal conditions (2.45; 2.30, 2.61). Of all the groups with psychiatric conditions, claimants with ADHD had the highest likelihood of having their claim disallowed compared with any of the non-psychiatric groups, in keeping with the previous two analyses.

There was little variation in the likelihood of having a claim disallowed for individuals with psychiatric conditions compared to those with diabetes, aside from alcohol and drug users who were less likely (0.86; 0.79, 0.94) and claimants with ADHD who were more likely (1.48; 1.37, 1.59) to have their claim disallowed following a PIP eligibility assessment.

|                                       | <b>All psychiatric conditions</b> | <b>Psychosis</b>    | <b>Personality Disorder</b> | <b>Psychoneurosis</b> | <b>Behavioural disorder</b> | <b>Alcohol and drug use</b> | <b>ADHD</b>         |
|---------------------------------------|-----------------------------------|---------------------|-----------------------------|-----------------------|-----------------------------|-----------------------------|---------------------|
|                                       | <b>OR (95%CI) P</b>               | <b>OR (95%CI) P</b> | <b>OR (95%CI) P</b>         | <b>OR (95%CI) P</b>   | <b>OR (95%CI) P</b>         | <b>OR (95%CI) P</b>         | <b>OR (95%CI) P</b> |
| <b>All non-psychiatric conditions</b> | 2.40 (2.36-2.44)***               | 2.28 (2.23-2.32)*** | 2.28 (2.15-2.41)***         | 2.50 (2.44-2.55)***   | 2.39 (2.22-2.57)***         | 1.97 (1.85-2.10)***         | 3.38 (3.23-3.55)*** |
| <b>Musculoskeletal conditions</b>     | 2.98 (2.93-3.04)***               | 2.83 (2.77-2.89)*** | 2.83 (2.68-2.99)***         | 3.10 (3.03-3.18)***   | 2.97 (2.76-3.19)***         | 2.45 (2.30-2.61)***         | 4.20 (4.01-4.41)*** |
| <b>Neurological conditions</b>        | 1.12 (1.08-1.15)***               | 1.06 (1.03-1.09)*** | 1.06 (1.00-1.13)*           | 1.16 (1.12-1.20)***   | 1.11 (1.03-1.20)**          | 0.92 (0.86-0.98)*           | 1.57 (1.49-1.66)*** |
| <b>Diabetes</b>                       | 1.05 (0.99-1.11)                  | 1 (0.94-1.06)       | 1 (0.92-1.08)               | 1.09 (1.03-1.16)*     | 1.04 (0.95-1.14)            | 0.86 (0.79-0.94)***         | 1.48 (1.37-1.59)*** |

**Table 17. Odds ratios for claims disallowed following an eligibility assessment during reassessment from DLA to PIP for psychiatric conditions compared to non-psychiatric conditions. CI, 95% confidence intervals, \*<0.05, \*\*<0.01, \*\*\*<0.001**

‘Musculoskeletal conditions’ includes Arthritis, Back Pain, Diseases of Muscles, Bones and Joints, Spondylosis, ‘Neurological Conditions’ includes Epilepsy and Multiple Sclerosis.

### **8.3. Discussion**

This is, to the best of my knowledge, the first academic study to analyse administrative data on the outcomes of benefit reassessments in the UK by health condition. The analyses outlined here suggest that the reform of DLA to PIP has impacted negatively on claimants with mental illnesses. The findings show that claimants with psychiatric conditions are more likely to a) be financially disadvantaged compared to their previous DLA award and b) to lose their existing entitlement entirely following a reassessment of eligibility, compared to claimants with other health conditions. People with diabetes were the exception, where rates of disallowed claims following eligibility reassessments were similar to people with psychiatric conditions.

Although it is not clear from these analyses alone why there appears to be a disadvantage for people with mental illnesses in the transition to PIP, the findings and particularly those relating to claims disallowed following an eligibility assessment, chime with both the interview study undertaken as part of this research and the wider literature, in which people with mental illnesses have described feeling that their health condition is poorly understood during the assessment process (Shefer et al., 2016; Patrick, 2017).

More recently, the House of Commons Work and Pensions Committee has been gathering evidence on the experiences of claimants during PIP eligibility assessments. PIP claimants with mental illnesses have described problems of knowledge about mental illnesses on the part of assessors in relation to how this type of condition impacts on daily functioning, coupled with the use of ‘informal observation’, for example, appearance and body language to make broad inferences about the mental state of the claimant (House of Commons Work and Pensions Committee, 2018). The use of informal observation was also noted by claimants in the interview study described in the previous chapter, Jane for example, stated that she had been penalised in her assessment report for appearing ‘well presented’ which was felt to be incongruent with anxiety and depression. Whilst clinical psychiatric assessments may also use such informal observations, for example, ‘appearance and behaviour’ is a category in the mental state examination tool (Hulme-Dickens, 2013) widely used by mental health professionals, it forms only a small part of a detailed,

holistic assessment of symptoms and is not a standalone criterion – appearing well presented does not necessarily signify a higher level of functioning.

Further to this, assessment providers giving written evidence to the same Work And Pensions Committee inquiry in response to a question about whether the professional background of assessors is matched to the health condition experienced by the claimant stated that “Our role is not to diagnose or treat so specialist knowledge of, for example, mental health diagnosis and treatment is not necessary to be able to understand how an individual’s life is affected” (ATOS, 2018). As of November 2017, 16.6% of ATOS PIP assessors had a clinical mental health background (ATOS, 2018), suggesting the majority of assessors do not have prior experience of conducting assessments of psychiatric conditions.

The justification from providers such as ATOS, that specialist knowledge of diagnosis is not required, relates to the key change in the move from DLA to PIP, an updated eligibility assessment process focusing on how the person is affected by their illness rather than the severity of the condition itself (Department for Work and Pensions, 2016). This transition from symptoms-based to functional assessment aims to focus on what the person ‘can do’, taking account of aids and adaptations and comes with a requirement to attend a face to face assessment as standard (Department for Work and Pensions, 2011).

One of the stated aims of the reform of extra-cost disability benefits is also to reduce costs (Fullfact, 2017) and altering eligibility criteria may also fit in with this approach. There has been much concern amongst physically disabled claimants, for example, that being able to mobilise independently is assessed on the basis of walking a much shorter distance under PIP compared to DLA, reducing the number of claimants who receive financial support for this criterion (Cross, 2013). Similarly, in March 2017, it was announced that claimants would no longer be able to claim the mobility component of PIP on the grounds of psychological distress, meaning that only claimants with physical mobility difficulties would be eligible for the higher rate of award. Following a successful high court challenge in December 2017, this approach was described as ‘blatantly discriminatory’ against people with mental illness in the ruling (Public Law Project, 2017; Mind, 2017).



Whilst it should be noted that some claimants with mental health conditions have seen their award remain the same or increase following migration from DLA to PIP, it is worth highlighting that the number of claimants negatively affected in absolute terms is far higher for mental illness than for other health conditions. Overall, 47,741 claimants with a psychiatric condition had their existing DLA entitlement removed after undergoing a PIP eligibility assessment and 80,662 claimants were financially disadvantaged after migrating to PIP between 2013 and 2016. Whilst the aim of cutting costs has therefore undoubtedly been achieved, this represents a substantial number of people now without financial support to which they previously had access. Given the existing relationship between mental illness and disadvantage, the loss of further income, up to £141.10 per week, has the potential to entrench inequalities and to increase the detrimental effects of financial strain and stress on mental health.

This study has considered psychiatric conditions relative to other health conditions to explore differences in reassessment outcomes. The intention is not to suggest that the proportion of claims disallowed for non-psychiatric conditions is at an acceptable level but rather to highlight potential areas of disadvantage which may need addressing to ensure equitable access to financial support. Parity of esteem has recently been enshrined in law for the National Health Service (The King's Fund, 2017) and these findings raise the question as to whether parity of esteem should be extended to cover other public institutions such as the welfare system, so that people with mental illnesses do not become even more marginalised as a result of their health conditions.

### **Limitations**

This study focuses on existing DLA claimants but does not consider the outcomes of new claimants of PIP who have not previously sought financial support for their mental health condition. The political response to the recent mobility payments ruling is that all those currently in receipt of PIP will have their claim reassessed and backdated payments provided where required (Department for Work and Pensions, 2018). This decision does not, however, appear to take account of all those who may have had their claim disallowed entirely at the eligibility assessment phase because they did not gain enough points to meet the criteria for payments since their mobility

needs were not included. Future research, using data from March 2017 onwards, when rules on mobility payments for psychological distress were implemented, could examine whether these changes had any impact on the number of claims disallowed, although it would be difficult to prove that any difference in numbers was solely related to this particular rule change.

From these aggregated data it was not possible to determine an independent baseline level of health-related needs for claimants undergoing reassessment of their existing DLA entitlement or to incorporate individual characteristics such as age or gender into the analysis. It is feasible, for example, where health conditions are chronic and remitting as may be the case for some psychiatric illnesses, that the existing level of financial support was not required at the point of reassessment. This is also true across some of the comparator conditions in the analysis (e.g. people with back pain), however, and raises questions as to why claimants would choose to undergo a reassessment with the associated stress this may entail, if no longer in need of financial support. Nevertheless, the data is comprised of individuals with an identified health-related need, previously assessed independently as being at a level requiring financial support.

Future analysis could explore other reassessment outcomes by health condition, for example, the number of claims that were awarded following an eligibility assessment but where the financial entitlement has been increased, particularly given that this has provided justification for changes to the existing payment system. Consideration should also be given as to why individuals with diabetes experience similar proportions of disallowed claims to people with mental illness as evidenced in the final analysis. It was also not possible to disaggregate the psychoneurosis category by type of illness; therefore, it is possible that a whole spectrum of claimants is represented here, from milder forms of dysthymia through to severe depressive illness, with potentially differing claim outcomes. If data were provided that facilitated such an analysis, future research could focus on exploring outcomes by severity of illness.

The rollout of PIP reassessments did not occur uniformly, and this may have implications for outcomes over time between 2013 and 2016. Reassessment was undertaken based on the type of claim rather than incorporating, for example, all

individuals claiming DLA in a particular postcode, and so the likelihood of the data being influenced by the characteristics of an area is low, but it is possible that learning over time from these early assessments could have influenced later outcomes. Any alterations to the process may have acted either in favour or against claimants with mental illnesses who were assessed further along in the implementation period.

#### **8.4. Conclusion**

Extra-cost disability benefit reform has been used in this analysis to explore the impact of welfare policy changes on individual outcomes. There are many more examples of changes associated with recent welfare reform in the UK that are beyond the scope of this research but the impact of which on outcomes for claimants with different health conditions should be investigated.

This study has demonstrated that people with mental illnesses appear to have been disadvantaged by the transition from DLA to PIP, as compared to claimants with other health conditions, both in terms of financial award and in relation to eligibility assessments. Although it is not possible from this analysis to say why people with mental illnesses have been disadvantaged by these changes, the findings fit with qualitative research findings on claimant perceptions. This means that a substantial number of people with mental illnesses now have less access to financial support than previously, with possible implications for exacerbating existing links with poverty and social exclusion. For individual claimants who have had their existing award removed, this may act as a discrediting experience.

## **Chapter 9: Cross-national analysis of structural economic factors and public attitudes towards mental illness**

## **9.1. Introduction**

This chapter reports on the findings of the cross-national, comparative analysis described in Chapter 6. The research questions were as follows:

1. Are macro socioeconomic factors (GDP per capita, income inequality, disability poverty and social exclusion gap) associated with public attitudes towards mental illness across European countries?
2. Are mental health spending decisions associated with public attitudes towards mental illness across European countries and if so, is the relationship independent of GDP per capita and income inequality?
3. Are disability protection spending decisions associated with public attitudes towards mental illness across European countries and if so, is the relationship independent of GDP per capita and income inequality?

## **9.2. Findings**

### **9.2.1. Descriptive Statistics**

*Outcome variable: Difficulty speaking to a person with a significant mental illness*

On average, around a quarter (24.73%) of respondents across the EU-27 would find it difficult to speak to a person with a significant mental illness, although there is considerable variation by country, see Table 18. The sample for each country includes around 1,000 respondents aside from Luxembourg, Cyprus and Malta where numbers are around 500. This is because sampling is proportionate to population size and so smaller countries have fewer respondents (TNS Opinion and Social, 2010).

|                        | <b>Difficult talking to someone with a significant mental health problem<br/>N (%)</b> | <b>No problem talking to someone with a significant mental health problem<br/>N (%)</b> | <b>Don't know<br/>N (%)</b> | <b>Total<br/>N</b> |
|------------------------|--|---|-----------------------------|--------------------|
| <b>France</b>          | 270 (25.64)  | 727 (69.04)   | 56 (5.32)                   | 1,053              |
| <b>Belgium</b>         | 240 (23.26)  | 752 (72.87)   | 40 (3.88)                   | 1,032              |
| <b>The Netherlands</b> | 166 (16.44)  | 822 (81.39)   | 22 (2.18)                   | 1,010              |
| <b>Germany</b>         | 263 (16.71)  | 1117 (71.01)  | 193 (12.26)                 | 1,573              |
| <b>Italy</b>           | 252 (24.14)  | 623 (59.67)   | 169 (16.19)                 | 1,044              |
| <b>Luxembourg</b>      | 83 (16.44)   | 405 (80.20)   | 17 (3.37)                   | 505                |
| <b>Denmark</b>         | 207 (20.62)  | 756 (75.30)   | 41 (4.08)                   | 1,004              |
| <b>Ireland</b>         | 201 (19.82)  | 683 (67.36)   | 130 (12.82)                 | 1,014              |
| <b>Great Britain</b>   | 208 (20.43)  | 762 (74.85)   | 48 (4.72)                   | 1,018              |
| <b>Greece</b>          | 328 (32.80)  | 607 (60.70)   | 65 (6.50)                   | 1,000              |
| <b>Spain</b>           | 162 (16.10)  | 768 (76.34)   | 76 (7.55)                   | 1,006              |
| <b>Portugal</b>        | 334 (32.36)  | 569 (55.14)   | 129 (12.50)                 | 1,032              |
| <b>Finland</b>         | 206 (20.50)  | 685 (68.16)   | 114 (11.34)                 | 1,005              |
| <b>Sweden</b>          | 154 (15.34)  | 826 (82.27)   | 24 (2.39)                   | 1,004              |
| <b>Austria</b>         | 237 (23.49)  | 638 (63.23)   | 134 (13.28)                 | 1,009              |
| <b>Cyprus</b>          | 32 (6.34)  | 427 (84.55)   | 46 (9.11)                   | 505                |
| <b>Czech Republic</b>  | 206 (20.16)  | 740 (72.41)   | 76 (7.44)                   | 1,022              |
| <b>Estonia</b>         | 344 (34.40)  | 587 (58.70)   | 69 (6.90)                   | 1,000              |
| <b>Hungary</b>         | 258 (24.81)  | 667 (64.13)   | 115 (11.06)                 | 1,040              |
| <b>Latvia</b>          | 373 (37.00)  | 574 (56.94)   | 61 (6.05)                   | 1,008              |
| <b>Lithuania</b>       | 533 (52.46)  | 366 (36.02)   | 117 (11.52)                 | 1,016              |
| <b>Malta</b>           | 107 (21.40)  | 308 (61.60)   | 85 (17.00)                  | 500                |
| <b>Poland</b>          | 328 (32.80)  | 547 (54.70)   | 125 (12.50)                 | 1,000              |
| <b>Slovakia</b>        | 339 (32.85)  | 636 (61.63)   | 57 (5.52)                   | 1,032              |
| <b>Slovenia</b>        | 136 (13.53)  | 800 (79.60)   | 69 (6.87)                   | 1,005              |
| <b>Bulgaria</b>        | 359 (35.72)  | 460 (45.77)   | 186 (18.51)                 | 1,005              |
| <b>Romania</b>         | 232 (22.01)  | 428 (40.61)   | 394 (37.38)                 | 1,054              |
| <b>Total</b>           | 6,629 (24.73)  | 17,500 (65.29)  | 2,671 (9.96)                | 26,800             |

Table 18. Outcome variable descriptive statistics by country

Scatter plots were created in the first instance to explore the relationship between each of the contextual variables and the outcome variable: the proportion of those who would find it difficult to speak to a person with a significant mental health problem, for each country. All associated graphs and correlations are available in Appendix 6. Observation of the distribution of responses on the graphs show that Lithuania and Cyprus are consistently outliers because of the respectively high and low numbers of people reporting difficulty talking to a person with a significant mental health problem. The decision was taken not to remove these countries from the analysis, however, since there were already a relatively low number of countries in some of the models and because the analysis is intended to be a reflection of the real-world context.

Correlations demonstrate that disability poverty and social exclusion gap ( $R^2=0.00$ ,  $p=0.910$ ) and mental health spending change ( $R^2=0.00$ ,  $p=0.835$ ) represent the weakest relationships with the outcome variable whilst income inequality ( $R^2=0.36$ ,  $p=0.001$ ) and GDP per capita ( $R^2=0.33$ ,  $p=0.001$ ) are most strongly associated with attitudes towards people with mental illness. Higher income inequality and lower GDP per capita are both correlated with greater difficulty talking to a person with a significant mental illness. Both mental health spending and disability protection spending have a stronger association with the outcome variable in 2005/6 than 2010.

Although the focus of the chapter is on the final multilevel models as discussed in Chapter 6, the initial regression models have been included here for reference in Table 19 because they are referred to on several occasions in the reporting of the findings in the next section. As discussed in Chapter 6, disability protection spending was not taken forward for the multilevel models. Tables detailing comparisons of the logistic and multilevel logistic regression models are available in Appendix 7.

| Variable/Model   | 1<br>N=23,711      | 2a(i)<br>N=10,591  | 2a(ii)<br>N=10,591 | 2a(iii)<br>N=10,591 | 2b(i)<br>N=23,427  | 2b(ii)<br>N=23,427 | 2c(i)<br>N=23,427  | 2c(ii)<br>N=23,427 | 2c(iii)<br>N=23,427 | 2d(i)<br>N=23,427  | 2d(ii)<br>N=23,427 |
|--|--------------------|--------------------|--------------------|---------------------|--------------------|--------------------|--------------------|--------------------|---------------------|--------------------|--------------------|
| <b>Difficulty paying bills never/almost never</b>      |                    |                    |                    |                     |                    |                    |                    |                    |                     |                    |                    |
| <b>From time to time</b>                               | 1.49(1.40-1.59)*** | 1.37(1.23-1.52)*** | 1.28(1.15-1.43)*** | 1.26(1.13-1.40)***  | 1.32(1.24-1.42)*** | 1.30(1.22-1.39)*** | 1.49(1.40-1.59)*** | 1.28(1.19-1.37)*** | 1.24(1.16-1.32)***  | 1.35(1.26-1.44)*** | 1.24(1.16-1.32)*** |
| <b>Most of the time</b>                                | 1.97(1.79-2.17)*** | 1.82(1.58-2.10)*** | 1.66(1.43-1.91)*** | 1.57(1.35-1.81)***  | 1.68(1.53-1.86)*** | 1.65(1.49-1.82)*** | 1.98(1.80-2.18)*** | 1.63(1.48-1.80)*** | 1.51(1.37-1.67)***  | 1.64(1.49-1.82)*** | 1.49(1.35-1.64)*** |
| <b>Age 16-25</b>                                       |                    |                    |                    |                     |                    |                    |                    |                    |                     |                    |                    |
| <b>26-39</b>   | 0.86(0.78-0.95)**  | 0.77(0.66-0.90)**  | 0.79(0.67-0.92)**  | 0.81(0.69-0.94)**   | 0.87(0.79-0.97)*   | 0.88(0.79-0.98)*   | 0.86(0.78-0.95)**  | 0.87(0.79-0.97)**  | 0.89(0.80-0.99)*    | 0.89(0.80-0.98)**  | 0.90(0.81-0.99)*   |
| <b>40-54</b>   | 0.79(0.71-0.88)*** | 0.68(0.58-0.79)*** | 0.70(0.60-0.82)*** | 0.72(0.61-0.84)***  | 0.81(0.73-0.90)*** | 0.82(0.74-0.91)*** | 0.79(0.71-0.87)*** | 0.82(0.74-0.91)*** | 0.84(0.75-0.93)**   | 0.82(0.74-0.91)*** | 0.84(0.76-0.93)**  |
| <b>55 years and above</b>                              | 0.92(0.84-1.01)    | 0.86(0.75-0.99)*   | 0.88(0.76-1.01)    | 0.90(0.78-1.04)     | 0.97(0.88-1.06)    | 0.96(0.87-1.05)    | 0.91(0.83-1.01)    | 0.96(0.87-1.05)    | 0.99(0.89-1.09)     | 0.97(0.88-1.06)    | 0.99(0.89-1.09)    |
| <b>Male</b>  |                    |                    |                    |                     |                    |                    |                    |                    |                     |                    |                    |
| <b>Female</b>  | 0.83(0.78-0.88)*** | 0.82(0.75-0.90)*** | 0.82(0.75-0.89)*** | 0.82(0.75-0.89)***  | 0.83(0.78-0.88)*** | 0.82(0.78-0.87)*** | 0.83(0.78-0.88)*** | 0.82(0.77-0.87)*** | 0.83(0.78-0.88)***  | 0.83(0.78-0.88)*** | 0.82(0.78-0.87)*** |
| <b>Mental health spending 2005</b>                     |                    | 0.92(0.91-0.94)*** | 0.98(0.96-1.00)    | 0.98(0.96-1.00)     |                    |                    |                    |                    |                     |                    |                    |
| <b>Mental health spending change 2005-2010</b>         |                    | 1.00(0.98-1.02)    | 1.05(1.03-1.08)*** | 1.03(1.01-1.06)**   |                    |                    |                    |                    |                     |                    |                    |
| <b>Disability protection spending 2006</b>             |                    |                    |                    |                     | 0.99(0.99-0.99)*** | 1.00(1.00-1.00)*** |                    |                    |                     |                    |                    |
| <b>Disability protection spending change 2006-2010</b> |                    |                    |                    |                     | 1.00(1.00-1.00)*** | 1.00(1.00-1.00)*** |                    |                    |                     |                    |                    |
| <b>Poverty and social exclusion gap</b>                |                    |                    |                    |                     |                    |                    | 0.99(0.99-1.00)    | 0.98(0.97-0.99)**  | 0.97(0.97-0.98)***  |                    |                    |
| <b>Income inequality (Gini)</b>                        |                    |                    |                    | 1.04(1.03-1.05)***  |                    |                    |                    |                    | 1.06(1.05-1.07)***  | 1.08(1.07-1.09)*** | 1.05(1.05-1.06)*** |
| <b>GDP per capita (Euros)</b>                          |                    |                    | 0.99(0.99-0.99)*** | 0.99(0.99-0.99)***  |                    | 0.99(0.99-0.99)*** |                    | 0.99(0.99-0.99)*** | 0.99(0.99-0.99)***  |                    | 0.99(0.99-0.99)*** |

Table 19. Logistic regression models. CI, 95% confidence intervals, \*<0.05, \*\*<0.01, \*\*\*<0.001



### **9.2.2. Multilevel models**

For all of the final models, the comparison between logistic and multilevel logistic regression analyses suggests that the multilevel structure is a better fit for the data. This is indicated by the likelihood ratio tests for each multilevel model, which are all highly statistically significant ( $p < 0.001$ ). The intraclass correlation (ICC) associated with each of the models suggests that there is variance present that can be explained by differences between countries as well as within countries (Twisk, 2006). The ICC for Model 2d(iii) for example, suggests that approximately 4% (95% CI: 0.02, 0.08) of variance in the model including income inequality and GDP per capita can be explained by differences between countries.

For ease of reporting, the final full multilevel models are summarised in Table 20, and these will form the focus of the findings and discussion section of the chapter. Numbering has been kept the same as the logistic regression models to enable comparison and the models are ordered with the most simple model first (Model 2d.iii – compositional factors + GDP per capita + income inequality only), followed by the model including income inequality, GDP per capita and mental health spending (Model 2a.iii) and income inequality, GDP per capita and the disability poverty and social exclusion gap (Model 2c.iii). As the effects of mental health spending disappeared once income inequality and GDP per capita were added to the multilevel model (see Table 20), the decision was taken not to analyse both mental health spending and the disability poverty and social exclusion gap together in a further model.

| Variable/Model                                    | 2d(iii)<br>N=23,347 | 2a(iii)<br>N=10,591 | 2c(iii)<br>N=23,347 |
|---|---------------------|---------------------|---------------------|
| <b>Difficulty paying bills never/almost never</b> |                     |                     |                     |
| From time to time                                 | 1.25(1.16-1.34)***  | 1.19(1.07-1.33)**   | 1.25(1.16-1.34)***  |
| Most of the time                                  | 1.52(1.37-1.68)***  | 1.49(1.28-1.73)***  | 1.52(1.37-1.69)***  |
| <b>Age 16-25</b>                                  |                     |                     |                     |
| 26-39   | 0.89(0.80-0.98)*    | 0.80(0.69-0.94)**   | 0.88(0.80-0.98)*    |
| 40-54   | 0.82(0.74-0.91)***  | 0.70(0.60-0.82)***  | 0.82(0.74-0.91)***  |
| 55 years and above                                | 0.97(0.88-1.08)     | 0.87(0.75-1.01)     | 0.97(0.88-1.08)     |
| <b>Male</b>                                       |                     |                     |                     |
| Female  | 0.81(0.77-0.87)***  | 0.81(0.74-0.89)***  | 0.81(0.77-0.87)***  |
| Income inequality (Gini)                          | 1.06(1.01-1.10)*    | 1.04(0.97-1.11)     | 1.06(1.02-1.11)**   |
| GDP per capita (Euros)                            | 0.99(0.99-0.99)*    | 0.99(0.99-1.00)     | 0.99(0.99-0.99)**   |
| Mental health spending 2005                       |                     | 0.99(0.88-1.11)     |                     |
| Mental health spending change 2005-2010           |                     | 1.05(0.93-1.19)     |                     |
| Poverty and social exclusion gap                  |                     |                     | 0.96(0.92-0.99)*    |
| LR test   | 424.23***           | 126.89***           | 401.86***           |
| ICC   | 0.04 (0.02-0.08)    | 0.05(0.02-0.11)     | 0.04 (0.02-0.07)    |

Table 20. Odds ratios for full final multilevel models. CI, 95% confidence intervals, \* $<0.05$ , \*\* $<0.01$ , \*\*\* $<0.001$ .

### 9.2.3. Compositional factors

In each of the models, individual financial status was strongly and consistently associated with attitudes towards people with mental illness. In model 2d(iii) for example, compared to those who reported never or almost never having difficulty paying their bills, those who described difficulties some of the time were 1.25 (1.16, 1.34) times more likely to report having difficulty talking to a person with mental illness and those who described difficulty paying bills most of the time were 1.52 (1.37, 1.68) times more likely. This finding, that people experiencing greater financial difficulties are more likely than those who are not to report difficulties talking to a person with mental illness was present across all the models and represents a significant ( $p<0.001$ ) difference in attitudes based on individual financial circumstances.

Age is also important across the models, with tolerance increasing the older the respondent, as compared to a person aged 16-25 years old. The association is strongest in those aged 26-39 and 40-54, whilst there is little difference between the youngest and oldest groups of respondents. This increased tolerance in those aged between 26-54 compared to the youngest and oldest respondents could suggest that cohort effects rather than age may be driving the difference in attitudes here. Gender also has a strong and consistent effect across the models, with males more likely to report experiencing difficulty talking to a person with mental illness than female respondents.

#### **9.2.4. Contextual factors**

The association between rates of mental health spending and attitudes towards people with mental illness weakens considerably once GDP per capita and income inequality are added into the models. Although mental health spending change over time, designed to represent decisions on the proportion of resources dedicated to mental health care as part of overall health spending does initially show a statistically significant association with attitudes towards mental illness (see Table 19), this effect disappears once the model is altered from standard logistic to multilevel logistic regression, meaning that once country effects are controlled for in the final model (Table 20, model 2a.iii), there is no association between mental health spending change and attitudes towards people with mental illness.

GDP per capita has a relatively small but consistent association with attitudes towards mental illness and once added to the models, has accounted for some of the effect of other variables such as the association between disability protection spending and attitudes. Higher GDP per capita is associated with greater tolerance, in this instance (0.99, 95% CI: 0.99-0.99) but this is a small effect. Despite this representing a relatively small increase in tolerance, the influence of GDP per capita on each of the models does suggest that the wealth of a country is associated with public attitudes towards people with mental illness.

Similarly, income inequality is consistently associated with attitudes towards mental illness and this relationship is stronger than that of GDP per capita. This association

suggests that the more unequal a country, the less tolerance there is towards people with a mental illness (1.06, 1.01-1.10). This association remains unaltered after controlling for country effects and GDP per capita, suggesting that income inequality exerts an independent effect above that of the wealth of a nation or characteristics of particular countries. The relationship between GDP per capita, income inequality and difficulty talking to a person with mental illness is perhaps unsurprising given the strong correlation between these co-variables and the outcome variable noted in the original scatter plots, but the finding that these variables continue to show a strong association after compositional factors have been controlled for suggests an independent association between these wider economic factors and individual attitudes.

The disability poverty and social exclusion gap is also associated with attitudes towards mental illness so that the smaller the gap between people with disabilities who experience poverty and social exclusion and the general population, the greater the likelihood that individuals will have no difficulty talking to a person with a mental illness (0.96, CI: 0.92, 0.99). This association is only visible once GDP per capita and income inequality are added to the models, suggesting that these broader economic factors may also be associated with the size of the gap.

In the multilevel model including all three of these contextual factors (model 2ciii) – GDP per capita, income inequality and the disability poverty and social exclusion gap, it is still the individual factors that explain by far the greatest amount of variance and the country level factors that explain the least, demonstrated by the intraclass correlation of 0.04 (0.02, 0.07). Nevertheless, considering the multitude of possible influences on attitudes across each of the countries in the sample, that these three factors are able to explain 4% of the variance in attitudes is not insubstantial. Contextual factors such as these are important because they have the potential to impact on all people living in a particular country.

### **9.3. Discussion**

This analysis has shown that both compositional and contextual factors are important in determining whether or not people across European countries experience difficulty talking to a person with mental illness.

In terms of demographic characteristics, the findings suggest that both age and gender are associated with attitudes towards people with mental illness in this context, with females reporting less difficulty talking to a person with mental illness than males in the sample. Age is more complex, with the oldest and youngest respondents in the sample more likely to report difficulty talking to a person with mental illness than those in the 26-54 age group. This is an interesting finding given that traditionally in attitudinal research; younger people usually report more tolerant attitudes than older respondents (Cornelis et al., 2009). In the context of attitudes towards mental illness, however, this finding of greater tolerance amongst those in the middle age bracket has been replicated in research conducted in the UK in the same time frame.

In the Attitudes to Mental Illness survey, a nationally representative study completed in the UK most recently in 2012, respondents aged 35-54 gave the most tolerant responses compared to those in both younger and older age brackets, albeit there were nuances by particular questions (Mind and Rethink Mental Illness, 2013), suggesting that tolerance towards people with mental illness increases rather than decreases with age. This may be related to a higher likelihood of having known a person with mental illness during the lifespan. The findings of this analysis are therefore consistent with previous research on attitudes to mental illness and it is also feasible that this is a cohort effect, so that people in the 26-54 age bracket have perhaps had different experiences than those in the older and younger generations. The climate of recovery focused mental health care and anti-stigma campaigns over the past twenty years could have influenced this age group more than others, alongside an ever-increasing number of people reporting mental health difficulties over time. This means that the likelihood of having experienced illness personally or knowing someone who has may be greater for this age group. This does not explain less tolerant attitudes amongst younger respondents, however, given that this cohort

has also grown up during a time of greater awareness about mental illness and higher numbers of people experiencing it.

Of all the compositional factors, however, it was difficulty paying bills that had the strongest association with experiencing difficulty talking to a person with a mental illness. Here, there was a gradient of decreasing tolerance, with less likelihood of tolerance for each increment of financial difficulty. Those in the worst financial position were 1.52 times more likely to report difficulty talking to a person with mental illness than those in the best financial position. This is a striking difference and suggests that individual economic circumstances may be a driver of attitudes towards people with mental illness.

In relation to contextual factors, the most consistent effects were those of GDP per capita, income inequality and the disability poverty and social exclusion gap. Higher GDP per capita, alongside more equal countries and those with a lower disability poverty and social exclusion gap were all associated with more positive individual attitudes towards people with mental illness. When all of these variables are included in the same model, they are able to explain more of the variance and each exerts an independent effect on the outcome variable. People with mental illnesses who live in countries with lower GDP per capita, that are more unequal and have a larger poverty and social exclusion gap between disabled people and the general population may be more likely to experience stigma than those who live in countries with different socioeconomic characteristics.

This would suggest that the wider socioeconomic climate of a country is associated with differences in attitudes towards people with mental illnesses. Furthermore, it is feasible that the wider socioeconomic climate and individual financial circumstances are closely linked. Those in the worst financial positions in countries that are more unequal may experience the effects of relative social status more acutely (Layte, 2012; Daly, Boyce and Wood, 2015) and this could be manifested in greater levels of intolerance. Similarly, where GDP per capita is lower, the stress associated with being in a difficult personal financial situation may be more acute because it is likely that there are less financial resources or wider economic opportunities than in countries where GDP per capita is higher. The likelihood of a higher disability poverty and social exclusion gap in countries where GDP per capita is lower may be

greater because the resources to support people with disabilities are less likely to be available and labour market barriers may be increased given that economic resources in general are sparser in these contexts.

It is less clear as to how the disability poverty and social exclusion gap links with income inequality to form an association with attitudes towards mental illness, however, several explanations are possible. Firstly, the disability poverty and social exclusion gap in more unequal countries may be a reflection of the wider inequalities between rich and poor that are affecting the country as a whole. As people with disabilities are more likely to experience socioeconomic deprivation, it is possible that in more unequal countries, this is felt most acutely by the most vulnerable who were already part of the population experiencing financial difficulties. Second to this, it could be that more unequal countries are less likely to provide the financial safety net required by the most vulnerable to achieve economic security.

This is an unexpected finding in terms of the broader literature on attitudes towards mental illness. Contact with people experiencing mental illness is one of the most effective ways to improve attitudes (Thornicroft et al., 2016) and in more unequal countries, rates of mental illness are higher (Pickett and Wilkinson, 2010; Burns et al., 2014). Hypothetically, therefore, in a more unequal country, the likelihood of having contact with a person with mental illness should be higher and this should inadvertently improve levels of tolerance. Unfortunately, however, in all countries, it is those who are most socioeconomically deprived who have the greatest likelihood of experiencing mental illness (World Health Organisation, 2014). In more unequal countries, where there is a greater gap between rich and poor, it is possible that a significant number of the population have much less contact with people living in poverty and by extension, individuals with a mental illness.

### **Spending decisions**

This analysis found little evidence of an association between disability public protection spending or mental health spending and attitudes towards mental illness. This was also true for spending change, which was originally hypothesised as representing decisions that could work either in favour or against attitudes towards people with mental illness. In answer to research questions two and three, the findings would suggest that there is no evidence of an effect of spending decisions

on public attitudes towards mental illness or vice versa, once other macro socioeconomic factors are taken into account.

The findings relating to spending decisions do not fit in with the existing literature on the impact of policy decisions on individual outcomes in relation to mental illness, albeit this is so far limited (Hatzenbuehler and Link, 2014; Pachankis et al., 2015). This analysis intentionally did not include cultural norms in exploring structural socioeconomic factors because the aim was to look only at spending decisions. The inclusion of cultural norms has the potential to conflate public attitudes and structural factors so unlike existing research, this analysis sought to separate the two. It is possible that in previous analyses that have included policy decisions and cultural norms, it is actually cultural norms that are accounting for more of the variance in the relationship between structural factors and individual outcomes or experiences of stigma.

Alternatively, in the case of mental health spending at least, it is possible that there are problems with the variable itself that have produced difficulties in the analysis. Data on mental health spending was only available for 13 countries in the sample and this is quite a low number with which to complete multilevel analysis as previously discussed. It is far below the recommended number of country level variables for carrying out this type of analysis (Bryan and Jenkins, 2016). To varying degrees, there is an effect of both mental health spending in 2005 and mental health spending change in the basic logistic regression models but these effects disappear once the variables are added to the multilevel models. It is possible that using only 13 countries in the sample has therefore caused problems with the model itself.

Second to this, although there is differentiation in the values of this variable by country and there is a good distribution across the sample of increased and decreased spending in terms of spending change, these differences are on the whole relatively small because mental health spending is a relatively minor part of the overall health budget. Further to this, it is unlikely that many members of the public are aware of both disability protection spending or mental health spending figures and therefore if an association had been found between public spending and attitudes towards mental illness, it is feasible that this could be acting as a proxy for something else, perhaps an associated reduction of economic resources as the findings relating to income



inequality and GDP per capita suggest. This is possibly why the association between spending decisions and attitudes is weakened once these broader economic variables are included in the models.

A related point is that the health budget and social security system are not the only place that resources are derived for people with mental illnesses. In the UK, for example, resources are also derived from Local Authorities through social services and personal care budgets that are then used to access third sector providers and charities. In countries where healthcare is privatised or accessed via a combination of state transfers and private insurance, for example, Germany, funding becomes even more complex and this variable becomes more problematic. In fact, it is possible that countries that are spending more on mental health care from their health budget rather than social care have higher levels of hospitalisation and fewer individuals with mental illness living in the community.

### **Limitations**

One of the key limitations of this study is the age of the data and the impact this has on the relevance of the findings. It is possible that since the 2010 Eurobarometer was administered, that there have been changes to attitudes towards mental illness. Whilst there has been mixed evidence of change over time in existing research (Dinos, 2014; Angermeyer et al., 2014a), there are many factors that could influence levels of tolerance towards people with mental illness, not least more effective anti-stigma campaigns. Without a detailed exploration of these factors in each country, it is unclear whether the outcome variable continues to represent reliable levels of tolerance.

Similarly, there have likely been significant changes across Europe in relation to the socioeconomic climate in each country. The data in this study is taken from a time period directly after the recession when many countries were struggling economically, and this is likely to have had a direct impact on individual financial circumstances and the disability poverty and social exclusion gap because a contracting labour market could mean larger barriers for disabled people seeking employment. Research suggests that this certainly applies to people with mental illnesses (Evans-Lacko et al., 2013). Reductions in public spending have the

potential to increase income inequality and to have a more pronounced impact on individual financial circumstances. Furthermore, attitudes towards minority groups are often more negative following periods of recession (Johnston and Lordan, 2016). Recent evidence that attitudes towards welfare claimants in the UK are softening (Baumberg-Geiger, 2017) might also suggest that were the study to be conducted using more recent data, the impact of sustained public spending cuts might have the opposite effect.

The study findings could therefore be an artefact of the context in which they are situated rather than being generalisable to broader economic factors. They do provide valuable information, however, on the type of economic factors that could have impacted on the stigma associated with mental illness in the post-2007 recession context. Ultimately, however, the study provides little information as to the mechanisms by which wider socioeconomic factors are associated with attitudes towards mental illness and this requires further exploration.

Further limitations to the study relate to the method. The outcome variable here, difficulty talking to a person with mental illness, has been interpreted as a measure of tolerance but it does not necessarily follow that where difficulty talking to a person is expressed, that it represents intolerance. A person may feel anxious about talking to a person with mental illness, for example, because they do not know anyone with this type of condition, but this does not necessarily mean the person is averse to the idea of meeting or interacting a person with a mental illness. In this context, reports of difficulty talking to a person with a mental illness could be suggestive of a lack of knowledge, which in the cognitive-behavioural model of stigma, is distinct from negative emotional reactions that lead to prejudice, albeit the two are often linked (Thornicroft, 2006). If the outcome variable is suggestive of a form of stigma, then there is little detail as to the specific nature of this prejudice, for example, fear, anger, blame. It is also possible to interpret this variable as more representative of social contact than of tolerance per se, although given the strong links between social contact and stigma, this would actually make the variable a good option for determining the impact of public attitudes.

It is also worth noting that although the study has focused on those factors that could produce greater intolerance towards people with mental illnesses, across the

European countries in the sample, only 24.73% of respondents reported that they would experience difficulty talking to a person with a mental illness. It should be highlighted then, that three quarters of people in Europe would have no difficulty talking to a person with a significant mental illness, although there are differences by individual country.

This also raises the issue of social desirability bias, a common problem with attitudinal research. The Eurobarometer is conducted via face to face interview for the majority of respondents (Eurobarometer, 2010) and so it is possible that responses have been affected by interviewees wanting to appear more tolerant. Henderson et al. (2012) have found that whilst questions relating to knowledge about mental illness are not associated with social desirability bias, questions relating to intended behaviour towards people with mental illnesses are, particularly in face to face interviews compared to online surveys. Difficulty talking to a person with a mental illness constitutes an intended behaviour question and therefore social desirability bias could be implicated here. In this case, it is possible that the findings of this study understate the links between economic factors and attitudes towards people with mental illness. Don't know responses were excluded from the analysis but these could also be a reflection of social desirability bias, in which respondents are unsure as to the 'correct' answer. It is not possible to speculate as to the meaning behind this type of response, however, which is why the decision was taken not to incorporate this response category into the models.

In addition to the methodological limitations described above, there are several countries included in the analyses that may have unduly influenced the results. As is visible on the scatter plots, Cyprus is a consistent outlier with only 6% of respondents describing difficulty talking to a person with a significant mental illness and less immediately visible but potentially still problematic is Latvia, where 37% of respondents reported difficulty talking to a person with mental illness, a considerably higher proportion than other countries in the sample. Both of these form part of the thirteen countries on which mental health spending information was available. Whilst the decision was made to include these countries to improve the integrity of the analysis, it is possible that these two countries have impacted on the final results of the models. Romania also has a particularly high level of 'don't know' responses at 37.38%.

## **Implications of Findings**

Individual demographic differences in attitudes are more important in terms of explaining the proportion of people who have difficulty talking to a person with a significant mental health problem than contextual economic factors. The wider socioeconomic climate is important, however, and these factors do have an association with individual attitudes once demographic factors are controlled for in the models. Where the wider socioeconomic climate incorporates greater income inequality, lower GDP per capita and a wider disability poverty and social exclusion gap, there is less tolerance towards people with mental illness.

In relation to the research questions, this study set out to explore whether structural socioeconomic factors are associated with public attitudes towards mental illness. It has found that macro socioeconomic factors are associated with public attitudes (research question 1) but that disability protection spending and mental health spending are not associated with differences in public attitudes (research questions 2 & 3) once GDP per capita and income inequality are taken into account. In terms of the overall research aims, the study has highlighted that there is a relationship between the wider socioeconomic climate and interpersonal stigma, as manifested through attitudes towards people with mental illness.

It is possible that the lack of an association between spending decisions and attitudes towards mental illness is related to the way the variables are constructed in this particular analysis, or it is possible that there is simply no link between the two. The findings relating to income inequality and disability poverty and social exclusion gap are, however, interesting in this respect because both may be linked in with the welfare state.

Income inequality is lower in countries that have more generous welfare systems because economic redistribution through social security decreases the gap between rich and poor (Wang, Caminada and Goudswaard, 2012). People with disabilities are more likely to be reliant on the welfare system for financial support than the general population, so where there is a larger disability poverty and social exclusion gap in a country, it is possible that there is less financial support for disabled residents that would otherwise reduce these income differences. It may be therefore, that income inequality and the disability poverty and social exclusion gap are acting as a proxy

for how wide-reaching the welfare state is in a particular country. Whilst as previously stated, people generally may have less awareness of varying degrees of public spending; the effects of lower welfare state provision may be inadvertently linked with less tolerance. Welfare systems are, however, very complex and proving the existence of an association conclusively in this way would be very difficult, especially since there are also potentially labour market barriers to take into consideration here.

Nevertheless, it is possible that income inequality and the disability poverty and social exclusion gap do together represent a particular socioeconomic climate in which tolerance may be increased or decreased depending on these factors. There is evidence that in countries where the welfare state is retracting, attitudes towards claimants become increasingly negative (Hansen et al., 2013) and as previously stated, there are links between the welfare reform narratives associated with reducing welfare provision that, in the UK at least, may have increased negative attitudes towards disabled people (UNCRPD, 2016). As the data used for this analysis is taken from the period shortly after the recession hit across Europe, welfare states may have been impacted more acutely during this time.

It is also possible that the clear association between individual financial circumstances and attitudes towards mental illness is a reflection of the wider socioeconomic climate, so that whilst contextual factors are important, they are strongest when measured by individual financial circumstances. Research focusing on experiences of anticipated discrimination amongst people with major depression finds that those living in high income countries were twice as likely to report anticipated discrimination in relation to employment than those in low and middle income countries, which the authors suggest may be due to more competitive labour markets and individualised explanations of mental illness (Lasalvia et al., 2015). Equally, there is a well-documented link between lower education, which is associated with lower incomes, and less tolerant attitudes towards marginalised groups (Rustenbach, 2010) so it is possible that the relationship between difficulty paying bills and difficulty speaking to a person with a mental illness is simply a reflection of this.

This study has found evidence of associations between economic factors and attitudes towards mental illness but the models do not provide information about the direction of causality. It is, however, unlikely that attitudes towards people with mental illness would be one of the causes of individual hardship or have direct influence over wider economic factors such as income inequality and so it appears that the wider socioeconomic climate is driving public attitudes here. Alternatively though, to return to theories of the rise of neoliberalism as discussed in the background section, it is possible that a more individualised, competitive outlook in certain countries could produce negative attitudes and concurrently drive greater levels of economic inequality, for example, through voting behaviours. In such an environment, disabled people may experience greater financial difficulty. Certainly, in terms of the disability poverty and social exclusion gap, more negative attitudes towards people with mental illnesses could cause a greater likelihood of exclusion and more barriers, for example, to education or the labour market.

Regardless of the direction of causality, however, it is possible to conclude that where the socioeconomic climate of a country includes higher levels of income inequality and a greater poverty and social exclusion gap between disabled people and the general population, there is greater intolerance towards people with mental illnesses.

#### **9.4. Conclusion**

This chapter has set out the findings in relation to a cross-national comparative study designed to explore the association between micro and macro socioeconomic factors and public attitudes towards mental illness across European countries. It has detailed the process of analysis, including development of the models from basic logistic regression through to the use of multilevel structures.

This study has found strong and consistent associations between age, gender and individual financial circumstances in relation to public attitudes towards mental illness. It has also found that income inequality, GDP per capita and the disability poverty and social exclusion gap are key macro socioeconomic factors that are associated with stigma and that these can act to produce more or less tolerant socioeconomic climates for people with mental illnesses.

# **Section D: Overall discussion and Conclusions**

## **10.1. Introduction**

This chapter will aim to detail the relevance of the findings to the thesis as a whole and to address overarching theoretical and methodological issues as they relate to the research. In doing so, it will not repeat the discussion sections of earlier chapters apart from to provide examples of how the findings relate to overall themes. Following this, the chapter will consider the broader implications of the research.

In the first instance, I will provide a summary of key findings of each of the research studies and ask whether these provide evidence of links between socioeconomic factors and the stigma associated with mental illness at both the interpersonal and structural level. The discussion will centre primarily around whether the aims of the thesis have been addressed.

Second to this, I will discuss the findings in relation to the theoretical stigma model outlined in the background section and consider how the research fits in to the critical realist framework. The chapter will debate the methodological issues arising from the thesis, including the generalisability and validity of the findings, alongside how well the mixed methods framework has been adhered to.

After reflection on the overall limitations of the thesis, the chapter will then consider broader research and policy implications before making a series of recommendations.

## **10.2. Key Findings**

The analysis section of the thesis reported on three distinct studies undertaken to explore the links between socioeconomic conditions and the stigma associated with mental illness.

Interviews on the lived experiences of individuals with mental illnesses focused on welfare claimants to explore the role of stigma in this particular socioeconomic context. Interviewees overall described mixed experiences of their interactions with the welfare system. Some claimants had found this to be a supportive and trouble-free experience, whilst others described difficulties in relation to eligibility assessments and more general barriers to accessing financial support. The study



could not find any discernible differences in outcomes by type of mental illness or by gender although given the sample size, the findings do not necessarily lend themselves well to the detailed study of trends.

Whether or not the claims process was acceptable to interviewees, most described finding the process stressful. This was particularly true given that the majority of participants were unable to work due to ill health and so benefits represented their main source of income. The stress attached to the process of obtaining and maintaining payments in this context affected self-esteem, mood and for three participants, led to suicidal ideation.

The main driver of the stress described by participants here appeared to be related to economic power differentials. Conditionality in particular was perceived to be acting with an extended reach beyond the original aim of behaviour change in those looking for work and towards a pervasive and covert influence throughout the claims process, including within eligibility assessments. Even where interviewees had made a successful claim, the constant fear that sanctions might be applied or entitlement removed on an arbitrary basis had detrimental psychological consequences.

There was evidence of self-stigma amongst interviewees in the study but more often the reactions of participants appeared representative of felt stigma, whereby interviewees were aware of negative stereotypes about welfare claimants but did not feel these were personally applicable. In some cases, there was a clear and negative impact on self-esteem of being perceived as a welfare claimant, demonstrating an internalising of such stereotypes that is characteristic of self-stigma (Thornicroft, 2006). Most frequently though, interviewees described stereotypes as not personally applicable but as still having relevance to other claimants, creating a hierarchy of stigma that reflected how deserving other claimants were perceived to be. Drug and alcohol users, for example, were usually provided as examples of claimants who were not deserving of financial support. This means that whilst personally rejecting stereotypes of fraud and welfare dependency, these were still accepted as being accurate and left unchallenged by the majority of interviewees. This suggests that welfare reform narratives were entrenched amongst participants, even whilst their effects were recognised as being damaging to claimants.

Participants encountered further interpersonal forms of stigma from those around them, for example, family members, welfare system staff and the public. Such experiences appeared to be directly related to the interplay between dependency narratives and certain characteristics of mental illness. As invisible health conditions, people experiencing mental illnesses can often appear physically able and this appeared to affect the perceptions of others in relation to how ill the person was perceived to be. Even where mental illness was acknowledged by others, it was most often perceived as not being a valid reason to require social security payments and to be unable to work. As such, participants reported that their condition was not viewed by others as being a serious impairment. Mental illness appears to fall outside of traditional conceptualisations of disability when considered in relation to employment. In turn, this type of health condition has become associated with narratives of fraud and dependency, leading to stigmatisation.

Overall, this study suggests that welfare reform narratives permeate the experiences of people with mental illnesses who are accessing income benefits and produce associated and specific forms of stigma. Further to this, the design of the current claims process is perceived as disempowering by claimants. Given that income benefits such as ESA and PIP may represent the main source of income available to people who are unable to work due to mental ill health; that mental illness represents the health condition with the largest number of benefit claimants (Moncrieff and Viola, 2016) and that a significant employment gap remains between those with a mental health condition and the general population (OECD, 2012; Public Health England, 2018), a system that does not work effectively has the potential to increase social exclusion. Where the claims process is not acceptable to claimants, there is the potential for impacts on the uptake of financial support through underclaiming.

A welfare system able to support those unable to work due to mental ill health or who may face extra costs as a result of their illness is therefore key to addressing some of the existing socioeconomic inequalities experienced by people with mental illnesses but although the interview study found that access to social security is perceived as problematic by claimants with mental illnesses, it did not test whether there is an actual financial disadvantage. The second study in this series used administrative data to explore whether changes to extra-cost disability benefits (migration from DLA to PIP) have disadvantaged claimants with mental illnesses as

compared to people with other health conditions. Although there is evidence from qualitative studies (including the interview study conducted as part of this research) that people with mental illnesses feel that reformed eligibility assessment processes are not designed to meet their needs (see for example, Dwyer et al., 2016; Shefer et al., 2016) thus creating a disadvantage, there has been little evidence to date on actual claimant outcomes.

This study found that compared to claimants with a range of physical health conditions, people with mental illnesses were more likely to be financially disadvantaged by the transfer from DLA to PIP. This finding was evident in terms of overall reductions in payments and in relation to outcomes following an eligibility assessment specifically, where people with mental health conditions were 2.4 (2.36, 2.44) times more likely than other claimants to have their existing payments removed.

This analysis suggests that there appears to be a disadvantage for claimants following changes to extra-cost disability benefits in the UK that is associated with an aspect of having a mental illness. It is possible therefore that the stated policy aim of reducing the financial costs of disability benefits (Fullfact, 2017) has had a disproportionate impact on people with mental illnesses by acting indirectly through changes to the eligibility assessment process. It is important to note that such disadvantages may also exist for other groups of claimants, but this was not the focus of the current research. Losing an existing source of income (DLA) and one that is designed to assist with the extra costs associated with having a long-term health condition may have significant consequences for the financial and therefore social exclusion for people with mental illnesses.

The final study considered whether broader socioeconomic conditions are associated with public attitudes towards mental illness. Alongside individual demographic factors, it considered the role of public spending decisions as an indicator of policy approaches affecting people with mental illnesses as well as other socioeconomic conditions such as the level of income inequality and the disability poverty and social exclusion gap in a country. The intention here was to explore whether there is a relationship between macro socioeconomic conditions and the stigma associated with mental illness.

At the individual level, personal financial circumstances were most strongly associated with attitudes towards people with mental illnesses above other demographic factors such as age and gender. The study found that whilst public spending decisions in the areas of mental health and disability protection spending did not demonstrate an association with attitudes towards mental illness, other economic factors including income inequality, GDP per capita and the disability poverty and social exclusion gap did. This does suggest that there may be a relationship between the wider socioeconomic climate of a country and tolerance towards people with mental illness.

It is possible that the association between individual financial circumstances, in particular socioeconomic deprivation, and attitudes towards people with mental illnesses could be a representation of the wider socioeconomic climate, acting at the individual level. The study considered whether higher levels of income inequality and an increased poverty and social exclusion gap between disabled people and the general population could be indicative of socioeconomic climates in which welfare systems are less redistributive. Although it is not possible to extrapolate from the evidence provided by the cross-national analysis directly, this would fit with a context in which there is a scarcity of resources and people with mental illnesses are more likely to be blamed for their financial difficulties, which could explain the association between less tolerance and socioeconomic deprivation.

### **10.3. Findings in relation to overall thesis aims**

**To explore the relationship between micro level socioeconomic factors and the stigma associated with mental illness in the post-2007 recession context.**

The research has focused on micro level socioeconomic factors primarily in relation to welfare reform measures undertaken since 2007 in the UK. These include updated eligibility criteria, increased conditionality and the narratives attached to the changes. There has been little evidence to date exploring social security outcomes for people with mental illnesses and this is an important source of income for those who are unable to work due to their health condition or who experience extra costs

as a result of their illness. Changes to the welfare system therefore have the potential to influence the socioeconomic inequalities associated with mental illness.

The interview study has demonstrated that interpersonal forms of stigma are present for people with mental illness in the context of recent UK welfare reforms. The experiences of stigma recounted by participants suggests that negative attitudes towards welfare benefit claimants with a mental illness may be relatively widespread, or at least are perceived as such by claimants. There is evidence that the characteristics of mental illness, as invisible conditions that fall outside of traditional conceptualisations of disability, interact with existing narratives of welfare dependency and deservingness to increase stigma.

The most recent estimates in England suggest that the gap in employment rates between the general population and people with a long-term health condition is 29.4%, whilst for individuals with a mental illness who are accessing community mental health services, the gap is 67.4% (Public Health England, 2018). Although using contact with secondary services as a measure is likely to capture people with more severe forms of mental illness, this demonstrates the importance of having appropriate financial support available until people are able to work or societal barriers to employment are addressed. It is not clear from this research why mental illness is viewed as less valid than physical illness as a reason to require financial support, but it is feasible to suggest from the findings that these attitudes are associated with welfare reform narratives focusing on worklessness and fraud.

In line with previous research, interviewees reacted to such perceptions by expressing self-stigma, however, rather than internalising such beliefs, the most common reaction was to express a sense of feeling misunderstood. Participants explicitly highlighted their claim as being based on genuine need by comparing their situation to other claimants who were framed as less deserving. This distinction shows that whilst rejecting the idea that welfare reform narratives were personally applicable, interviewees believed they were true in general.

The contact hypothesis, which is well evidenced, suggests that higher levels of interpersonal contact with people experiencing mental illness increases tolerance (Thornicroft et al., 2016; Mental Health Foundation, 2017). Given that mental illness is strongly associated with individual experiences of poverty and area level

deprivation (Marmot, 2010), it should follow that others in a similar financial situation are more tolerant because the likelihood of coming into contact with people experiencing mental illness or of personally experiencing mental illness is greater. The cross-national comparison, however, suggests that the opposite is true, because here individual experiences of financial difficulties actually increased stigma. This may relate to the same mechanism by which claimants distinguish themselves as genuine by outlining a hierarchy of stigmatised identities. The effect is that individuals in difficult financial situations blame each other, whilst the wider structures that produce and maintain poverty remain hidden.

**To explore the relationship between macro level socioeconomic factors and the stigma associated with mental illness in the post-2007 recession context.**

In order to more fully assess the relationship between socioeconomic conditions and the stigma associated with mental illness, the thesis has considered macro as well as micro level economic factors. This is because individual financial circumstances often have structural drivers, particularly where access to social security payments is required but also in relation to labour markets, taxation, redistribution and so on. Forms of stigma may also have structural origins that are linked with individual experiences (Livingston, 2013; Hatzenbuehler and Link, 2014). The post-recession context across the UK and Europe has been characterised by broad social and political changes that could feasibly impact on how people with mental illnesses experience inequalities and are perceived by others.

The research has used administrative data on extra-cost disability benefits to explore how one policy initiative, which was designed to reduce overall costs of social security (Fullfact, 2017), has affected claimants with mental illnesses. That disadvantage is evident for people with mental health conditions does appear to support the reports of claimants who have described feeling that mental health conditions are not well understood in relation to eligibility for health-related income benefits, an evidence base that is growing and which was also evident during the interviews here. This provides an example of the way in which macro level socioeconomic factors may become inadvertently stigmatising because they invalidate the experiences of individuals and affect how they are perceived by others.

Stigma can be intentionally incorporated into welfare systems to discourage claims (Baumberg, 2016) and certainly the interview data would suggest that claimants with mental illnesses felt this was applicable in the current welfare reform context. This would suggest a form of direct structural stigma aimed at claimants with mental illnesses to discourage their use of the welfare system. Recent Government attempts to stop PIP mobility payments on the grounds of psychological distress, described by the high court in England as ‘blatantly discriminatory’ (Mind, 2017; Public Law Project, 2017) would support the theory that direct structural stigma is present in the welfare system for claimants with mental illness but it is difficult to conclude more broadly that there is an overt and intentional drive towards depriving people with mental illnesses of financial support. In fact, some claimants have seen their payments increase during the migration from DLA to PIP (Fullfact, 2017). There may be evidence of indirect forms of structural stigma, that by cutting overall costs, there has been a disproportionate impact on people with mental illnesses who form the largest group of disability benefit claimants.

The link between macro level factors associated with welfare systems and the stigma associated with mental illness is ultimately difficult to prove, not least because such systems have a high level of complexity and there may be a multitude of other factors impacting on this relationship. The findings do, however, suggest that certain macro socioeconomic factors are associated with public attitudes towards people with mental illnesses. In this way, the research is one of the first to demonstrate the association between broader economic factors and attitudes towards people with mental illness. Income inequality, a wider disability poverty and social exclusion gap and lower GDP per capita are all strongly associated with less tolerant attitudes.

This demonstrates a need to look towards structural as well as individual level factors when considering how best to reduce stigma. It also suggests that the way a country distributes economic resources impacts on tolerance and greater attention needs to be paid to such factors if further marginalisation of people with mental illness is to be avoided. Not only are people with mental illnesses at greater risk of poverty and social exclusion more broadly, in certain socioeconomic contexts this may be compounded by higher levels of stigma. The size of the disability poverty and social exclusion gap may be indicative of the presence or absence of an effective socioeconomic safety net for disabled people.

## **Findings in relation to theoretical framework**

The stigmatisation process proposed by Link and Phelan (2001), which underpins the thesis, suggests that labels linked to ‘undesirable characteristics’ act to produce negative stereotypes, in turn separating labelled individuals into a distinct category. Once separated, the person with mental illness may experience status loss that can subsequently lead to discrimination. This process takes place in the context of power, which enables dominant beliefs about which characteristics are viewed as undesirable to create separation and to produce the conditions for discrimination.

The findings make clear that there are macro socioeconomic factors associated with the stigma surrounding mental illness and this fits with the proposal that stigma requires particular societal conditions in order to thrive (Link and Phelan, 2001). Similarly, the linking of social security claimants to narratives of fraud and dependency links labels to undesirable characteristics, which in turn produces negative stereotypes. The interview study demonstrates that mental illness in particular has become associated with these narratives, or at least that it was perceived as such by interviewees. Arguably, that claimants legitimised notions of wide-scale fraud and dependency, even though personally detrimental and not reflective of their own stringent claims process, demonstrates that such narratives have become entrenched and may have a systemic basis.

The research does not directly prove that power is behind the stigmatisation process here, but it is implied, since social and economic conditions, including social security reforms, are derived from decisions generated by policy makers and those in positions of political influence. Conversely, disempowerment is observable in the research, through the experiences of individual claimants in relation to actual and implied forms of conditionality which acted as a form of coercion.

Link and Phelan (2001) suggest in their model that status loss precedes discrimination because once individuals are discredited, discrimination can take place unchallenged. When discussing macro socioeconomic conditions, however, this linear approach is somewhat restricted. In this research at least, it is also possible that discriminatory conditions have produced status loss for people with mental illnesses.



#### **10.4. Methodological framework and triangulation of findings**

The theoretical framework underpinning the research suggests that there are links between structural, public and self-stigma and the thesis set out to explore how these different forms of stigma might be associated in relation to socioeconomic factors. Whilst the three studies undertaken cannot be directly linked to each other, since they use different approaches and samples, the research has provided evidence of the ways in which each of the different forms of stigma could be associated through the underlying themes that have emerged.

Critical realism is premised on three ontological layers, the empirical, the actual and the real (Bhaskar, 1975; Zachariadis et al., 2013) and these are associated with three components that critical realist research seeks to identify – the context, the underlying mechanism and the outcome. This relationship can be described as follows: context + mechanism = outcome (Pawson and Tilley, 1997) cited in McEvoy and Richards (2006). The table below aims to triangulate the findings by demonstrating how they are situated in the critical realist framework. The actual findings are more detailed than this table is able to convey and are discussed in full during each of the preceding results chapters, however, the triangulation here has attempted to draw out some of the overarching themes and consider how these might fit together.

| Ontological Layers | Interview study   | Administrative data analysis  | Cross-national data analysis  |
|--------------------|---|---|---|
| Empirical          | Claimants perceive that mental illness is not viewed as a valid reason to be accessing social security payments by:<br>-Family members and the public<br>-The welfare system              | The transition from DLA to PIP has led to a) reduced payments overall and b) loss of payments following eligibility assessments, for people with mental health conditions compared to those with other health conditions. | Subjective social status, income inequality, the disability poverty and social exclusion gap and GDP per capita are associated with attitudes towards people with mental illnesses across European countries. |
| Actual             | Mental illness does not fit with traditional conceptualisations of incapacity.<br><br>Mental illness has become associated with narratives of fraud and dependency in the welfare system. | Changes to extra-cost disability payments have indirectly disadvantaged claimants with mental illnesses.<br><br>There are inequalities in access to state financial support by health condition.                          | Micro and macro socioeconomic factors produce differences in attitudes towards people with mental illnesses.  |
| Real               | There are socioeconomic drivers of the stigma associated with mental illness at both the interpersonal and the structural level.  |   |   |

Figure 10. Triangulation of findings

Critical realism asks whether or not research findings can be generalised to their underlying structures (Zachariadis et al., 2013). Although it is difficult to say with certainty from these findings whether the disadvantages described here can be characterised as structurally stigmatising against people with mental illnesses, it is clear that stigma at the interpersonal level is associated with structural socioeconomic factors. The outcome is that there may be socioeconomic climates of tolerance or disadvantage for people with mental illnesses. Socioeconomic factors therefore act as the context and forms of stigma as the mechanism. This is discussed further in the section relating to the broader implications of findings.

## **Generalisability of the research overall**

As standalone pieces of research, the interview study and the cross-national analysis are both problematic in terms of generalisability. Interviews were conducted in one city and so the findings here could be associated with specific assessment centres, and the cross-national analysis could be considered outdated. Arguably it is not the role of interviews focusing on lived experience to be generalisable to a wider population but nevertheless, these findings and those of other studies conducted in different areas of the UK (Garthwaite, 2015; Shefer et al., 2016; Patrick, 2017) are so strikingly similar that it is likely the themes are common to claimants with mental health conditions. In relation to the cross-national analysis, it is not clear whether the same findings would arise with more recent data or whether the findings are an artefact of the immediate post-recession context and further research would be required to explore these possibilities. The study does, however, contribute useful information about the way in which the broader socioeconomic climate could impact on attitudes towards people with mental illnesses and uses a large representative sample of individuals, therefore these findings could be applied to other economic contexts in Europe. It has also demonstrated new ways in which structural factors may be associated with stigma and this has the potential to be expanded on in future research.

The administrative data analysis cannot be generalised beyond the specific context of the transfer of claimants from DLA to PIP but the study does include most of the population of possible individuals affected by these changes within the timeframe, aside from those individuals whose health conditions were omitted from the final analyses. The findings are therefore generalisable to the specific migration of claimants from DLA to PIP, but it is not clear whether the same differences by health condition are present for other recent reforms.

## **Has the thesis measured stigma?**

Primarily, this is a question of construct validity (Johnston and Smith, 2010). The theoretical discussion of stigma outlined in the background to the thesis proposed that there are interpersonal forms of stigma, affecting both self-perception and attitudes towards people with mental illnesses, and structural stigma in which

institutions and societal level factors work to produce disadvantage for certain populations. It was proposed, using the model put forward by Bos et al. (2013), that each of the three forms of stigma are interlinked.

Interviews with claimants cannot be argued to provide objective evidence of stigma because as qualitative research, this study is necessarily grounded in the perspectives of the participants and the interpretation of findings by the researcher. This study could be argued to provide evidence of *perceptions* of stigma, however, and interviewees described being treated differently as a direct result of having a mental health condition. Some of the examples of self-stigma inferred in the findings could be argued instead to represent separate concepts, for example, self-esteem or shame, however, there is good evidence that low self-esteem and shame are the main components of self-stigma (Farrelly et al., 2015). There was also evidence from interviewees that they had internalised particular stereotypes, a key part of the self-stigma process (Thornicroft et al., 2006).

The administrative data analysis has measured and found a systemic disadvantage, but it is not clear that this amounts to a form of structural stigma or if the disadvantage only affects people with mental illnesses, although this characterisation would certainly fit with the perceptions of claimants in the interview study. Arguably, since there is a clear outcome for claimants in terms of a loss of financial support, these findings could be characterised instead as discrimination, which has been identified as a possible outcome of stigma (Thornicroft et al, 2006) but it is difficult to say this with certainty on the basis of this study alone. The cross-national analysis represents arguably the clearest example of the measurement of stigma because it directly measures attitudes towards people with mental illness, a key element of interpersonal stigma (Alexander and Link, 2003).

The development of the methodological approach to the thesis was based on being able to test whether different forms of stigma link together. In this way mixed methods provided the most appropriate approach, because it has enabled the drawing together of different data sources to explore both micro and macro socioeconomic factors and different types of stigma within the same piece of work.

The research diverges from traditional mixed methods approaches in some senses. Although primarily a sequential design, neither the qualitative or the quantitative

aspects of the research are prioritised (Plano Clark and Creswell, 2008). Overall though, the research does fit with the fundamental principles of mixed methods research in that each study has ‘complementary strengths’ and that the findings can be triangulated to identify underlying themes (Onwuebuozie and Burke Johnson, 2008) cited in Plano Clark and Creswell (2008). By approaching the study of stigma in the context of socioeconomic factors from both micro and macro perspectives, the research has arguably provided a more holistic account of stigma in this context and how it is enacted.

## **10.5. Limitations**

After starting out with an initial idea for the thesis of exploring links between socioeconomic conditions, stigma and mental illness, I was drawn to further understanding the current context of welfare reform because social security represents a key source of income for many people experiencing mental illnesses and because welfare systems have the potential to reduce socioeconomic inequalities. At the time of commencing the project, there was very limited research on mental illness in relation to welfare reform policies and even less specifically focusing on stigma in this context.

This has since changed, particularly in relation to qualitative research (see for example, Patrick, 2017; Dwyer et al., 2018) but there is still little quantitative evidence available to provide information about overall trends and the broader patterning of individual experiences. I had hoped to contribute towards addressing this gap with my research because although the importance of first hand experiences is clear, it is difficult to explore systemic or structural factors without employing larger scale datasets to assess for the presence of patterns and associations.

The research has not differentiated fully between different types of mental illness and it is possible that experiences of both stigma and the welfare system may be influenced by the specific health condition of the person. Psychosis may carry with it different forms and intensity of stigma to, for example, depression (Wood et al., 2014). Each condition is also likely to be assessed differently in relation to financial support. Whilst assessors without a mental health background may be less familiar

with the signs and symptoms of psychosis, for example, people with this type of condition may be more likely to be in contact with secondary mental health services and therefore have access to extended medical evidence to support their claim, compared to a person with a common mental disorder such as depression. These nuances between different conditions have the potential to impact on access to financial support and experiences of the welfare system.

The decision not to focus the project on a particular mental illness was taken because at the time of planning the research, such limited evidence was available that it was felt focusing on particular conditions would limit recruitment to the interview study in a practical sense but would also not offer much further information than was already available. By including multiple types of mental illness in the research, it has been possible to make some assessment of differences in experiences by mental health condition, to compare different types of mental illness in relation to outcomes and to develop a more in-depth knowledge base. It has also enabled exploration of the themes that cut across different types of mental illness, for example, the invisibility and perceived validity of mental illness in the context of the welfare system.

Although these studies found evidence of stigma in relation to mental illness in the welfare system and in the wider economic context, because the research only partially uses comparators, it is not possible to state with certainty that the stigma is specific to people with mental illness. Reports from other claimant groups and disability charities suggests similar perceptions that welfare reforms are problematic amongst people with a wide range of different health conditions (Roulstone, 2015) and there are other illnesses that could be characterised as invisible, therefore subject to similar problems in the assessment process. It is possible that the findings here are less a reflection of issues surrounding mental illness and more a reflection of the stigma attached to welfare claimants as a whole. Where mental illness does differ in this respect and what this research has shown, is that it is situated at the intersection between welfare reform narratives, invisibility and validity. Mental illness feeds into the stigma surrounding worklessness in which welfare claimants are perceived as misusing the system, because those who experience it usually appear physically able.

Ethnicity is a gap in this research that has not been considered in relation to mental illness, stigma and socioeconomic conditions. There is limited evidence to suggest ethnic differences in attitudes towards mental illness and this research has focused on the USA context (Rao, Fienglass and Corrigan, 2007) but the key area where ethnicity could be important is in relation to self-stigma. Research suggests that people from ethnic minority groups in the UK with a mental illness report high levels of both racial and mental-illness related discrimination (Rehman and Owen, 2013). There are higher rates of detention under the Mental Health Act, particularly under Section 136 which frequently involves police detention, for some ethnic minority groups and although whether this is directly related to ethnicity or to associated factors remains under debate (Gajwani, Parsons, Birchwood and Singh, 2016), hospitalisation is itself stigmatising. People from black and ethnic minority groups are also twice as likely to experience poverty as white groups in the UK (Weekes-Bernard, 2017). Taken together, this evidence suggests that ethnicity could be a key factor in exploring the intersectionality between mental illness, stigma and socioeconomic conditions. Race was not discussed by participants in the interview study but although information was not available on the ethnic group of claimants in the administrative data analysis, as all claimants in a time period have been captured here, it is likely that there are people of different ethnic backgrounds included in the sample. The focus of the cross-national analysis was on public attitudes and so the exclusion of ethnicity here is likely to have had less of an impact. It is possible; however, that people from ethnic minority groups may experience the effects of the different forms of stigma found here more acutely and this requires further investigation.

## **10.6. Implications of findings**

On balance, whilst it is not possible to suggest that the research demonstrates evidence of structural stigma in relation to welfare reform directly, it does suggest that broader socioeconomic structural factors are associated with public attitudes towards mental illness and experiences of stigma. Where the broader socioeconomic climate means less resources and greater inequalities, it may also lead to a rise in the stigma associated with mental illness.

Meanwhile, the focus of research and anti-stigma campaigns remains on the individual, interpersonal level. The findings discussed here, although requiring further expansion, demonstrate the value of taking structural factors into consideration in relation to stigma and mental illness and the implication of socioeconomic factors in the stigma associated with mental illness opens up new avenues for research.

In relation to current welfare reform in the UK, it is possible from this research to infer that changes to health-related income benefits have had a detrimental impact on people with mental illness. Whether in the form of individual distress and disempowerment or in evidence of disadvantage in relation to payments, these findings support the ever-growing body of research that suggests such reforms are problematic for claimants (Roulstone, 2015; Garthwaite, 2015; Patrick, 2017). It highlights, in particular, that changes to the eligibility assessment process are needed. The interview study detailed here does also highlight evidence of good practice and it is worth noting that not all experiences of the claims process have been negative.

Broader changes in attitudes towards people with mental illnesses who are welfare claimants is also needed to prevent stigma in this context. In an already difficult situation where an individual is unable to work and is living in poverty as a result of poor health, the addition of stigma has the potential to further compound existing mental health difficulties and social exclusion. If changes to narratives and attitudes do not occur, then the patterns of disempowerment historically associated with total institutions and which the transition to community-based models of care has tried so hard to eradicate, may simply be reimagined through the welfare system and through broader socioeconomic conditions that prevent people with mental illnesses achieving social inclusion and full citizenship.

Changes to socioeconomic conditions and their impact on people with mental illnesses were hypothesised in Chapter 2 as follows:

- Welfare system changes have created less financial support for people with a mental illness and the NIMBY phenomenon creates opposition to the



situating of housing for individuals with a mental illness in more (socially powerful) affluent communities.

- Supported housing for people with a mental illness become disproportionately situated in more disadvantaged neighbourhoods. This occurs alongside social housing provision and low-priced rental properties, which may also act as resources for people with long term disabling conditions.
- Socioeconomic deprivation increases social and geographical segregation and acts as a form of institutionalisation.
- Status loss occurs, and the stigma initially associated with mental illness becomes associated with the cumulative stigma of being mentally ill, socioeconomically disadvantaged and a welfare system user.
- This leads to a cycle of disadvantage which has the potential to affect not only the person themselves but other family members and also future generations.
- Those in more affluent areas, who may be more likely to hold power and status in relation to policy making have more limited social contact with individuals experiencing mental illness.

The geographical distribution of public spending reductions over the past ten years has had uneven and disproportionate effects across the UK, impacting particularly on those areas with historically higher levels of socioeconomic deprivation (Gray and Barford, 2018), including post-industrial and long term economically depressed areas with greater numbers of residents accessing out of work benefits (Hamnett, 2014). The findings of the thesis demonstrate how socioeconomic factors such as welfare system changes and an unequal distribution of economic resources may contribute to the social segregation and subsequent disempowerment hypothesised here. Meanwhile, explanations of poverty increasingly focus on individual behaviour rather than on broader socioeconomic determinants such as changes to local and national labour markets (Pemberton et al., 2016). In the context of recession, people with long-term health conditions or disabilities may be particularly vulnerable to unemployment (Hamnett, 2014) and may consequently become subject to stigma

attached to beliefs that unemployment is an individual ‘choice’ (Pemberton et al., 2016).

Social models of disability place emphasis on disabling environments rather than individuals (Dwyer, 2004). This research has shown that socioeconomic conditions can act to create disabling environments by creating disadvantage for people with mental illnesses and climates of intolerance. Where broader socioeconomic conditions are more unequal and there is a scarcity of resources for people with disabilities, as this research has found, a greater likelihood of stigmatising attitudes towards people with mental illness may arise. This means that any positive measures to combat stigma may be counteracted by socioeconomic conditions that serve to perpetuate stigma.

Exclusion then becomes a question of citizenship. Kelly (2006) describes the economic exclusion of people with mental illnesses as a form of structural violence that ultimately creates a ‘power gap’. Whilst there is little existing evidence on voting patterns for people with mental illnesses, the secondary characteristics that have become associated with mental illness, such as homelessness and poverty, may put people at greater risk of disenfranchisement (Kelly, 2006) and lead to a cycle of disempowerment. Twine (1994) argues that access to material resources through the welfare state is a social right and this in turn underpins civil and political rights. Where social rights are not upheld, this leads to social exclusion that in turn will compromise citizenship. This is because social exclusion makes civil and political rights more difficult to exercise which perpetuates the uneven distribution of power. Mental illness is associated not only with higher levels of unemployment but also with lower social capital (Aslund, Starrin and Nilsson, 2014), which in turn may impact on efforts to build the capacity to reduce the power gap.

An effective welfare state acts as an important buffer for people with long term health conditions and disabilities, particularly where capacity to work may fluctuate and people may be vulnerable to labour market changes. Watters (2012) argues that full citizenship is premised not only on entitlement to economic and social rights, but also whether these are accessible. Citizenship for people with mental illnesses will be achieved when entitlement is augmented by interventions to ensure equal access to social and economic resources (Watters, 2012).

The recent release of a new joint strategy between the Department of Health and the Department of Work and Pensions (2017), titled *Improving Lives: The Future of Work, Health and Disability* suggests that changes may be imminent. The overarching aim of the strategy is to place 1 million people with long-term health conditions in work over the next ten years, with a particular focus on those with mental health and musculoskeletal conditions. For people with mental health conditions, this includes tailored support through the welfare system, the health service and with employers. Work can act to mediate the stigma associated with mental illness by providing both access to material resources and increased self-worth (Yang et al., 2014). This approach may have the potential to improve some of the societal barriers to employment currently experienced by people with mental illnesses therefore addressing some of the socioeconomic inequalities discussed here, provided a non-stigmatising approach to service users is adopted.

Alternative economic approaches that address inequalities through more inclusive labour markets and improved social protection are likely to greatly enhance social inclusion (Stiglitz et al., 2014; Macintyre et al., 2018). Changing worldwide financial markets and economies to be more inclusive of people with disabilities is arguably a significant and long-term challenge but how we react to those who are currently disadvantaged is more immediately modifiable. Where poverty is accompanied by blame and disempowerment, this has the potential to increase mental health difficulties and marginalisation. Where countries recognise the impact of financial difficulties on mental health and provide an appropriate financial safety net to those who may be particularly vulnerable to fluctuations in the labour market or who are unable to work due to ill health, the result will be a less stigmatising environment for people living with mental illnesses.

## **10.7. Recommendations**

### **Review of the claims process for health-related income benefits**

Evidence gathering and a review of claimant experiences has already been undertaken in relation to the PIP claims process (Gray, 2017; House of Commons Work and Pensions Committee, 2018) but the findings here suggest that any health-

related assessments need to be reviewed specifically in relation to people with mental illness. The claim that assessors need not be clinically trained in particular health conditions because eligibility assessments are functional rather than symptom based (ATOS, 2018) has clearly not been effective in practice. Changes to the assessment criteria are needed along with further research focusing on the training and experiences of assessors. Guidance from assessment providers suggests that assessors are provided with mental health specific training prior to undertaking assessments (ATOS, 2018) but it is clear that there is a gap between intended outcomes here and the reality of claimant experiences.

An approach towards welfare claims that emphasises entitlement rather than dependency would also benefit all disabled claimants, including those with mental illnesses. Critics have argued that the social model of disability has been misappropriated during recent welfare reforms, so that social security is now used less to create a 'level playing field' for people with disabilities and more to penalise claimants for any aids and adaptations that facilitate independence, an approach which has 'corrupted' language used in social models of disability (Morris, 2011). A more supportive environment is needed for claimants that reverses the damaging effects of existing narratives which are stigmatising and may worsen mental health outcomes. By empowering claimants, an entitlement-based approach may promote the individual autonomy that is the stated aim of workfare approaches (Ben-Ishai, 2012).

### **A social model of mental health and stigma**

Health inequalities researchers have been at the forefront of recognising and addressing the social determinants of illness more broadly, but dominant theoretical models of the causes and treatment of mental illness remain largely individualised. Greater attention paid to the role of macro socioeconomic factors in preventing full social integration and a subsequent focus on addressing these inequalities will benefit people living with mental illnesses. In particular, recognition should be given to socioeconomic factors as a barrier to social integration when planning care and working towards recovery. Further attention to the importance of these factors paid at the point of supporting the person to become part of a community, for example, discharge from hospital, could also enhance social integration.

Experiences of direct stigma should be recorded at point of contact with mental health services, similar, for example, to hate crime recording and monitored over time because stigma has the potential to significantly impact on social integration and therefore recovery. Without detection, experiences of stigma cannot be addressed and may further exacerbate the existing mental health condition.

Historically, the role of power in mental health systems has been much discussed and changes to care and treatment, whilst some would argue still do not go far enough, have been moving for some time now in the direction of greater equality between services and service users. This discussion needs updating, however, to account for the changing landscape of community focused models of care. The power-threat-meaning network is a conceptual framework for understanding mental illness that has been co-produced by the British Psychological Society and people affected by mental illness (Johnstone and Boyle, 2018). It is designed with the aim of viewing the treatment of people with mental illnesses through the lens of power structures rather than simply as a matter of individual biomedical pathology. It seeks to frame mental illness as an understandable reaction to patterns of inequality, deprivation and marginalisation and in doing so, emphasises the need for greater focus on rights-based approaches to address the existing adversities faced by people with mental illness (Grant and Gadsby, 2018). Forthcoming work by Tyler and Slater (2018) seeks to explore the role of power in replicating patterns of stigma and discrimination so this may offer opportunities to develop these frameworks further.

### **Forms of stigma are interlinked and should be treated as such**

Researching forms of stigma as distinct and separate components without considering intersectionality or micro-macro links fails to recognise the context in which stigma exists. This thesis has demonstrated the value of intersectional understandings of stigma and further research focusing on how different forms of stigma link together is key to understanding how stigma arises and is maintained. In order to explore intersecting forms of the stigma associated with mental illness, a greater availability of data is required. Recording routine data on individual experiences of stigma would assist in this respect and greater attention should be paid to designing research that moves away from traditional, interpersonal approaches to the study of stigma and towards assessing underlying structural

factors. Whilst this is not a novel approach to the study of stigma, this research has demonstrated the benefit of taking an intersectional approach.

### **Parity of Esteem**

Clearly, there is evidence to suggest that welfare reform in the UK has caused difficulties for many claimants regardless of health status or type of disability. Until recently, however, the difficulties faced by people with mental illnesses and the linking of reduced financial support with existing patterns of marginalisation has not been emphasised. Ultimately people with mental illnesses have felt the effects of welfare reform particularly acutely, with impact not only on individual financial circumstances but on social exclusion that is associated with the wider experience of poverty.

It seems that the most effective way to ensure that people with mental illnesses have access to the same rights and opportunities as other people, is to extend the reach of the parity of esteem agenda, which would provide a way of publicly highlighting existing inequalities and ensuring a statutory duty to address some of the links between mental illness and socioeconomic deprivation. This is not to suggest that all systems people with mental illness access are inherently discriminatory, but that by introducing a duty to ensure equality, conscious consideration will be given to ensure fair treatment and allocation of resources. A similar approach has recently been advocated by the Mental Health Foundation through their 'Mental Health in All Policies' approach (Elliot, 2016). Anti-stigma campaigns should also highlight that stigma consists not only of direct experiences of prejudice or discrimination but is also reflected in social inequalities, because where stigma is present in the social conditions that produce opportunity structures, it will lead to poorer outcomes amongst those who experience it (Randall et al., 2012). In this way it can be argued that stigma is a social determinant of health that must be addressed at both the individual level and in relation to disabling environments, if equal citizenship for people with mental illnesses is to be guaranteed.

## **10.8. Final conclusions**

In writing this thesis, I set out with the aim of understanding whether there are links between socioeconomic factors and the stigma associated with mental illness in the post-2007 recession context across the UK and Europe.

The background section outlined different types of stigma and evidence as to the effects on individuals who experience it, centring on conceptualisations of stigma as a discrediting experience that promotes social exclusion. Moving beyond traditional theorisations of stigma as an interpersonal concern, the literature review sought to demonstrate the value of considering stigma at the structural as well as individual level, inherent in systems and practices. In keeping with the aims of assessing the socioeconomic context of stigma, the literature review set out the evidence in relation to both micro and macro links between socioeconomic conditions and mental illness, proposing that the continued association between mental illness and socioeconomic disadvantage is grounded in the historical, political and economic context of mental health systems. The links between mental illness, stigma and the post-2007 economic context were then reviewed. Particular attention was paid to welfare reform and the impact of labour market barriers on people with mental illnesses, alongside the ideological narratives that have accompanied these economic changes.

The methodology for the three studies was outlined including the mixed methods approach and the critical realist framework for the research. Findings from interviews with welfare claimants experiencing mental illness revealed perceptions that this type of health condition is not well understood, particularly in relation to unemployment and the need for health-related income benefits. It is possible that this is because mental illness does not fit with traditional conceptualisations of disability. Although experiences of accessing social security were mixed, many of the sample described stigma, disempowerment and poverty. As such, recent changes to the social security system may be implicated in replicating patterns of marginalisation for people with mental illnesses. In addition to these findings, an administrative data analysis identified disadvantage for people with mental illnesses compared to those with other health conditions in relation to extra-cost disability benefit reform, potentially leading to increased financial difficulties. Whilst these studies focused on

the role of socioeconomic factors in relation to experiences of stigma and exclusion, the third study used a cross-national comparative analysis to explore associations between socioeconomic factors and attitudes towards people with mental illness. It found evidence of both micro and macro socioeconomic factors associated with attitudes, proposing that particular socioeconomic climates may be associated with tolerance or disadvantage.

Taken together, these findings suggest that socioeconomic conditions can add up to create disabling environments for people with mental illnesses, which entrench existing economic inequalities and promote social exclusion. Conversely, socioeconomic conditions that include an effective social security system, support with access to the labour market and that are focused on promoting equal social citizenship for people with mental illnesses may produce a lower likelihood of experiences of stigma and a greater likelihood of tolerance towards people with mental illnesses.

### **Future directions**

The findings of the thesis suggest a number of possible recommendations for further research. These are themed around ensuring that consideration is given to the socioeconomic context of stigma and how different forms of stigma intersect. In terms of the UK welfare system, greater attention needs to be paid to how the claims process functions for claimants with mental illnesses and more broadly, how to ensure parity of esteem between mental and physical health conditions across institutions. Doing so may assist with addressing some of the links between socioeconomic deprivation and mental illness. Key to further examining the role of stigma is more detailed data which could be recorded routinely for individuals and explored further at the structural level. An approach to stigma and mental illness grounded in a social rather than medicalised model would ultimately be beneficial.



# Appendices

## Appendix 1: Interview topic guide

### Topic Guide and Prompt Sheet

#### Before interview begins

Provide payment.

Sign consent and payment forms.

Discuss timing and outline of the topic areas.

Remind of right to withdraw/stop the interview/decline to answer questions.

Outline boundaries of confidentiality.

#### After interview

Check well-being and discuss next steps.

#### Topic Guide and Example Prompts

##### **Experiences of using housing and income benefits.**

*Can you tell me about your experiences of using housing and income benefits?*

##### **Perceptions of people who are unable to work due to mental ill health.**

*Do you think there is an understanding generally that people may sometimes be unable to work due to mental ill health?*

##### **Perceptions of attitudes towards mental illness and stigma.**

*Do you think the public and/or people that you come across in day to day life have an understanding about mental health issues [or individual diagnosis]?*

*Are people around you aware that you have mental health difficulties? Do you think that someone might be aware of this even if you did not tell them directly? If so, how?*

*Do you think stigma is an issue facing people with mental health issues more generally? Has this changed over time?*

##### **Being part of a community:**

- **Physical integration: Local area, access to resources, daily life/activities.**
- **Psychological integration: Sense of belonging.**
- **Social integration: Social support, social networks.**

*How do you find/can you tell me a bit about your local area? Do you feel part of a community?*

*What do you do with your time day to day?*

*Do you have people around you that you can talk to about any difficulties you might be having?*

*Do you attend any activities or spend time with other people regularly?*

*Does your income have any effect on your day to day life?*

## **Appendix 2: Interview study participant information sheet**



### **Participant Information Sheet**

#### **Title of Study: The experiences of people with mental illness in relation to welfare reform in the UK**

We would like to invite you to take part in this study which looks at the experiences of people with mental illness living in the community, who are accessing income and housing benefits.

Before you decide if you would like to be involved, please read the following information.

#### **What is the purpose of this study?**

There have been a number of changes to housing and income benefits in recent years and research has found that different groups of people have been affected by this in different ways. At the moment, not as much is known about how people with mental illness may have been affected and this study aims to find out more about this topic. Some people may not have noticed any changes and we are interested in hearing about your experiences too.

The study aims to gather information from those who are best placed to answer these questions, by asking people with mental health difficulties about their experiences directly. In doing so, this study hopes to further our understanding about some of these issues.

#### **Who is doing the study?**

Katie Pybus at the University of York will be conducting the study. This forms part of the research for a PhD in Health Sciences. The research is funded by the Economic and Social Research Council.

#### **Who is being asked to participate?**

We would like to speak with people aged between 18 and 65 who live independently (this can also mean living with family or friends) who have

difficulties with their mental health and are in receipt of social security payments (this includes housing benefit, employment support allowance, personal independence payments or disability living allowance).

### **Do I have to take part?**

Taking part in this research is entirely voluntary. After reading through this information sheet, you will be given some time to think about whether or not you would like to take part and if you are interested in finding out more, a meeting can be arranged with the researcher.

### **What will be involved if I take part in this study?**

If you decide to be involved in the study, you will take part in an interview with the researcher. This will be an informal conversation lasting up to an hour in which we will talk about some of your experiences of using housing and income benefits.

The interview can take place at the premises of your housing organisation or in most circumstances, at your home address. If you need to travel to meet the researcher, we will pay all reasonable expenses.

### **What are the advantages/benefits and disadvantages/risks of taking part?**

The study will help us to understand more about the experiences of people with mental illness in relation to income and housing benefits.

You will also be paid £10 for taking part in the study.

There are unlikely to be any risks to taking part in this study. You will not be asked to reveal any sensitive information about your illness and you can tell the researcher as much as you feel comfortable doing so.

### **Can I withdraw from the study at any time?**

You can choose to withdraw from the study at any time before or during the interview if you no longer wish to take part. Once the interview has taken place, any data you provide may still be used in the final research but this will always be kept strictly anonymous.

If you do decide to leave the study at any time, you do not need to give a reason for doing so.

**Will the information I give be kept confidential?**

Yes. The researcher will audio record your interview but your name and personal information will not be on the recording. Interviews are recorded only so that they can be accurately transcribed afterwards and once this has taken place, the recording will be destroyed. Your name or personal information will not be used in any writings or publications about the research. The researcher will use a password protected, encrypted device to complete the recordings to keep your information safe and this will be held securely at the University of York.

Finally, your data will always be managed within the boundaries of the Data Protection Act 1998.

**What will happen to the results of the study?**

Once all the interviews are complete, Katie Pybus will analyse the data and following this, you can request a verbal or written summary of the results. It is hoped that the results of the study can be published in research journals and in this case, you will be able to access a free copy of the article.

You can contact the researcher for an update on this process at any time.

**Who has reviewed this study?**

The Department of Health Sciences Research Governance Committee has provided ethical approval for this study.

**Who do I contact in the event of a complaint?**

If you wish to complain about this study, you can contact:

Professor Kate Pickett, PhD supervisor to Katie Pybus at: [kate.pickett@york.ac.uk](mailto:kate.pickett@york.ac.uk)

**If you agree to take part, would like more information or have any questions about the study please contact:**

**Katie Pybus**

**Email:** [kjp518@york.ac.uk](mailto:kjp518@york.ac.uk)

**Tel:** 07960 171707

*Thank you for taking the time to read this information sheet.*

**Appendix 3: Qualitative research distribution of codes and excerpts for interviewees.**

| <b>Interview</b> | <b>Total codes assigned</b> | <b>Total number of excerpts</b> |
|------------------|-----------------------------|---------------------------------|
| <b>1</b>         | 35                          | 82                              |
| <b>2</b>         | 27                          | 92                              |
| <b>3</b>         | 30                          | 66                              |
| <b>4</b>         | 16                          | 41                              |
| <b>5</b>         | 40                          | 143                             |
| <b>6</b>         | 35                          | 86                              |
| <b>7</b>         | 29                          | 99                              |
| <b>8</b>         | 30                          | 112                             |
| <b>9</b>         | 33                          | 104                             |
| <b>10</b>        | 24                          | 65                              |
| <b>11</b>        | 34                          | 109                             |
| <b>12</b>        | 30                          | 51                              |
| <b>13</b>        | 29                          | 59                              |
| <b>14</b>        | 32                          | 98                              |
| <b>15</b>        | 30                          | 69                              |
| <b>16</b>        | 31                          | 132                             |
| <b>17</b>        | 39                          | 105                             |
| <b>18</b>        | 40                          | 135                             |

**Appendix 4: Department for Work and Pensions summary table of reassessment outcomes by age of claimants.**

| <b>PIP Reassessment Outcomes</b> |                        |                        |                        |                                 |                                |                  |                |
|----------------------------------|------------------------|------------------------|------------------------|---------------------------------|--------------------------------|------------------|----------------|
| <b>Age Band</b>                  | <b>Award Increased</b> | <b>Award Unchanged</b> | <b>Award Decreased</b> | <b>Disallowed post-referral</b> | <b>Disallowed Pre-referral</b> | <b>Withdrawn</b> | <b>Total</b>   |
| <b>16 to 19</b>                  | 37%                    | 12%                    | 12%                    | 31%                             | 6%                             | 1%               | 29,800         |
| <b>20 to 24</b>                  | 36%                    | 11%                    | 14%                    | 31%                             | 6%                             | 1%               | 27,300         |
| <b>25 to 29</b>                  | 36%                    | 11%                    | 18%                    | 30%                             | 6%                             | 1%               | 28,000         |
| <b>30 to 34</b>                  | 36%                    | 10%                    | 20%                    | 28%                             | 5%                             | 1%               | 31,900         |
| <b>35 to 39</b>                  | 37%                    | 10%                    | 22%                    | 25%                             | 5%                             | 1%               | 38,300         |
| <b>40 to 44</b>                  | 39%                    | 11%                    | 23%                    | 23%                             | 4%                             | 1%               | 56,900         |
| <b>45 to 49</b>                  | 40%                    | 12%                    | 23%                    | 21%                             | 3%                             | 1%               | 69,500         |
| <b>50 to 54</b>                  | 41%                    | 12%                    | 25%                    | 18%                             | 3%                             | 1%               | 73,500         |
| <b>55 to 59</b>                  | 43%                    | 12%                    | 26%                    | 15%                             | 2%                             | 1%               | 74,500         |
| <b>60 to 64</b>                  | 42%                    | 14%                    | 28%                    | 13%                             | 2%                             | 1%               | 96,800         |
| <b>Total</b>                     | <b>40%</b>             | <b>12%</b>             | <b>23%</b>             | <b>21%</b>                      | <b>4%</b>                      | <b>1%</b>        | <b>526,500</b> |

## Appendix 5: 2x2 Tables for administrative data analysis (hypotheses A and B)

**Hypothesis A: Overall financial disadvantage following reassessment versus no financial disadvantage by number of claimants.**

1.

|                            | Disadvantage   | No Disadvantage | Total          |
|----------------------------|----------------|-----------------|----------------|
| All psychiatric conditions | 80,662         | 68,038          | 148,700        |
| Non-psychiatric conditions | 165,798        | 199,202         | 365,000        |
| <b>Total</b>               | <b>246,460</b> | <b>267,240</b>  | <b>513,700</b> |

2.

|                            | Disadvantage   | No Disadvantage | Total          |
|----------------------------|----------------|-----------------|----------------|
| Psychosis                  | 41,667         | 31,433          | 73,100         |
| Non-psychiatric conditions | 165,798        | 199,202         | 365,000        |
| <b>Total</b>               | <b>207,465</b> | <b>230,635</b>  | <b>438,100</b> |

3.

|                            | Disadvantage   | No Disadvantage | Total          |
|----------------------------|----------------|-----------------|----------------|
| Personality Disorder       | 3,906          | 2,394           | 6,300          |
| Non-psychiatric conditions | 165,798        | 199,202         | 365,000        |
| <b>Total</b>               | <b>169,704</b> | <b>201,596</b>  | <b>371,300</b> |

4.

|                            | Disadvantage   | No Disadvantage | Total          |
|----------------------------|----------------|-----------------|----------------|
| Psychoneurosis             | 25,823         | 26,877          | 52,700         |
| Non-psychiatric conditions | 165,798        | 199,202         | 365,000        |
| <b>Total</b>               | <b>191,621</b> | <b>226,079</b>  | <b>417,700</b> |

5.

|                            | Disadvantage   | No Disadvantage | Total          |
|----------------------------|----------------|-----------------|----------------|
| Behavioural Disorder       | 1,820          | 1,680           | 3,500          |
| Non-psychiatric conditions | 165,798        | 199,202         | 365,000        |
| <b>Total</b>               | <b>167,618</b> | <b>200,882</b>  | <b>368,500</b> |

6.

|                            | Disadvantage   | No Disadvantage | Total          |
|----------------------------|----------------|-----------------|----------------|
| Alcohol and Drug Misuse    | 2,548          | 2,652           | 5,200          |
| Non-psychiatric conditions | 165,798        | 199,202         | 365,000        |
| <b>Total</b>               | <b>168,346</b> | <b>201,854</b>  | <b>370,200</b> |



**7.**

|                              | Disadvantage   | No Disadvantage | Total          |
|------------------------------|----------------|-----------------|----------------|
| Hyperkinetic Syndrome (ADHD) | 4,898          | 3,002           | 7,900          |
| Non-psychiatric conditions   | 165,798        | 199,202         | 365,000        |
| <b>Total</b>                 | <b>170,696</b> | <b>202,204</b>  | <b>372,900</b> |

**Hypothesis B: Assessing differences in the number of individuals with a mental illness who have their claim for Personal Independence Payments disallowed following an eligibility assessment compared to those with other health conditions.**

**1.**

|                            | Claim disallowed post-assessment | All other outcomes | Total          |
|----------------------------|----------------------------------|--------------------|----------------|
| All psychiatric conditions | 47,741                           | 100,959            | 148,700        |
| Non-psychiatric conditions | 60,817                           | 304,183            | 365,000        |
| <b>Total</b>               | <b>108,558</b>                   | <b>405,142</b>     | <b>513,700</b> |

**2.**

|                            | Claim disallowed post-assessment | All other outcomes | Total          |
|----------------------------|----------------------------------|--------------------|----------------|
| Psychosis                  | 22,661                           | 50,439             | 73,100         |
| Non-psychiatric conditions | 60,817                           | 304,183            | 365,000        |
| <b>Total</b>               | <b>83,478</b>                    | <b>354,622</b>     | <b>438,100</b> |

**3.**

|                            | Claim disallowed post-assessment | All other outcomes | Total          |
|----------------------------|----------------------------------|--------------------|----------------|
| Personality Disorder       | 1,953                            | 4,347              | 6,300          |
| Non-psychiatric conditions | 60,817                           | 304,183            | 365,000        |
| <b>Total</b>               | <b>62,770</b>                    | <b>308,530</b>     | <b>371,300</b> |

**4.**

|                            | Claim disallowed post-assessment | All other outcomes | Total          |
|----------------------------|----------------------------------|--------------------|----------------|
| Psychoneurosis             | 17,391                           | 35,309             | 52,700         |
| Non-psychiatric conditions | 60,817                           | 304,183            | 365,000        |
| <b>Total</b>               | <b>78,208</b>                    | <b>339,492</b>     | <b>417,700</b> |

**5.**

|                            | Claim disallowed<br>post-assessment | All other outcomes | Total          |
|----------------------------|-------------------------------------|--------------------|----------------|
| Behavioural Disorder       | 1,120                               | 2,380              | 3,500          |
| Non-psychiatric conditions | 60,817                              | 304,183            | 365,000        |
| <b>Total</b>               | <b>61,937</b>                       | <b>306,563</b>     | <b>368,500</b> |

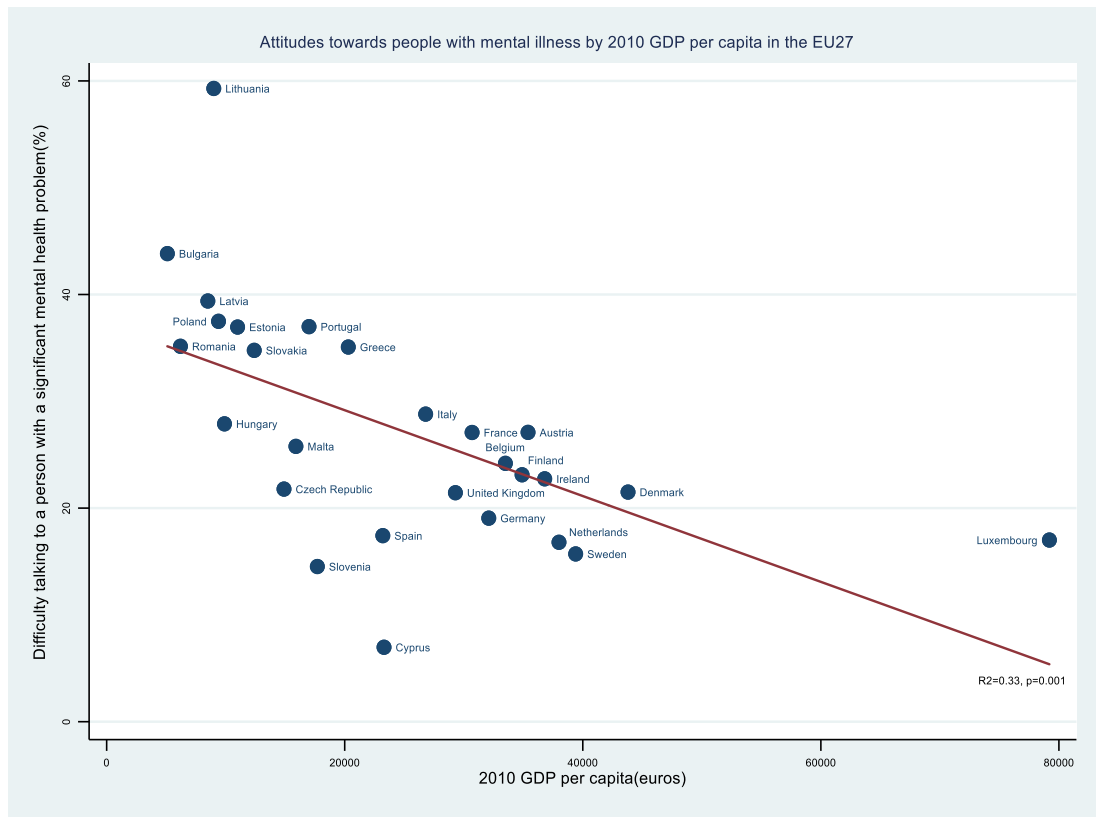
**6.**

|                            | Claim disallowed<br>post-assessment | All other outcomes | Total          |
|----------------------------|-------------------------------------|--------------------|----------------|
| Alcohol and Drug Use       | 1,456                               | 3,744              | 5,200          |
| Non-psychiatric conditions | 60,817                              | 304,183            | 365,000        |
| <b>Total</b>               | <b>62,273</b>                       | <b>307,927</b>     | <b>370,200</b> |

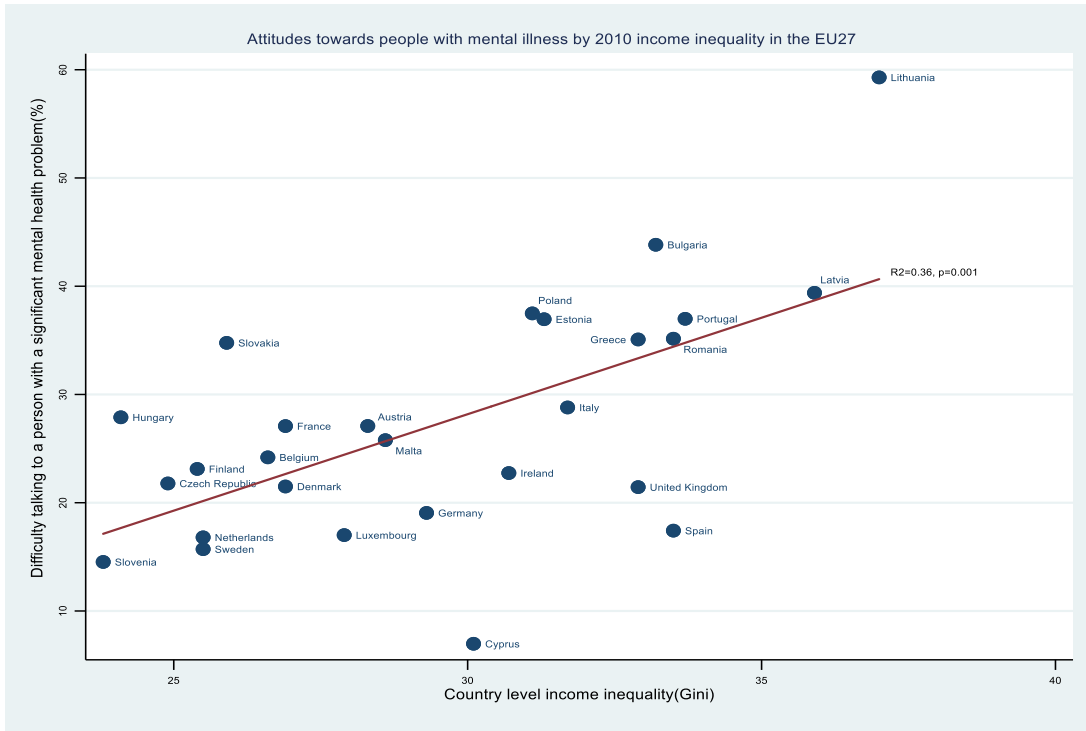
**7.**

|                              | Claim disallowed<br>post-assessment | All other outcomes | Total          |
|------------------------------|-------------------------------------|--------------------|----------------|
| Hyperkinetic Syndrome (ADHD) | 3,160                               | 4,740              | 7,900          |
| Non-psychiatric conditions   | 60,817                              | 304,183            | 365,000        |
| <b>Total</b>                 | <b>63,977</b>                       | <b>308,923</b>     | <b>372,900</b> |

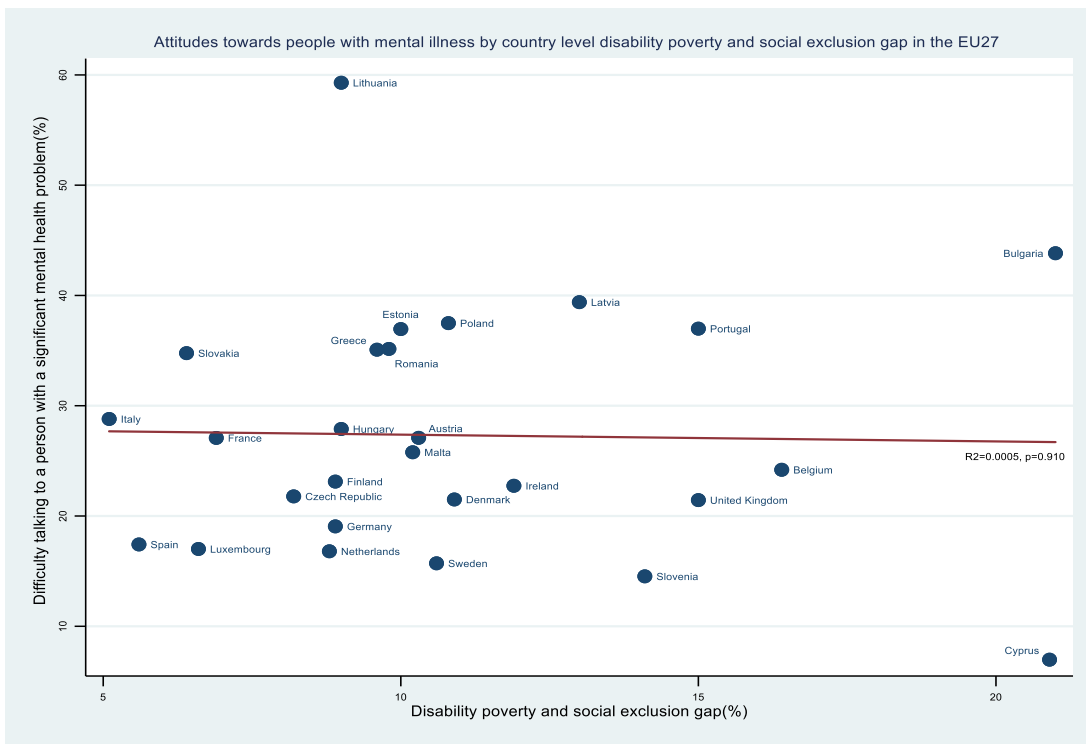
## Appendix 6: Cross-national analysis graphs and correlations



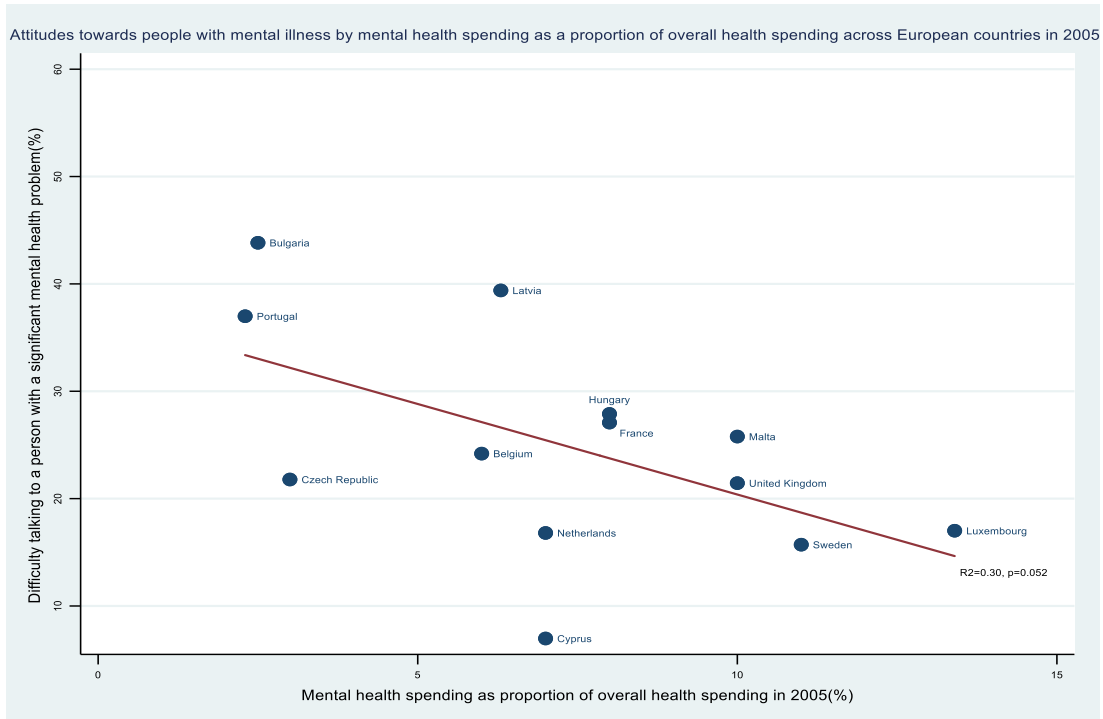
Proportion of respondents finding it difficult to talk to a person with mental illness by GDP per capita across the EU27



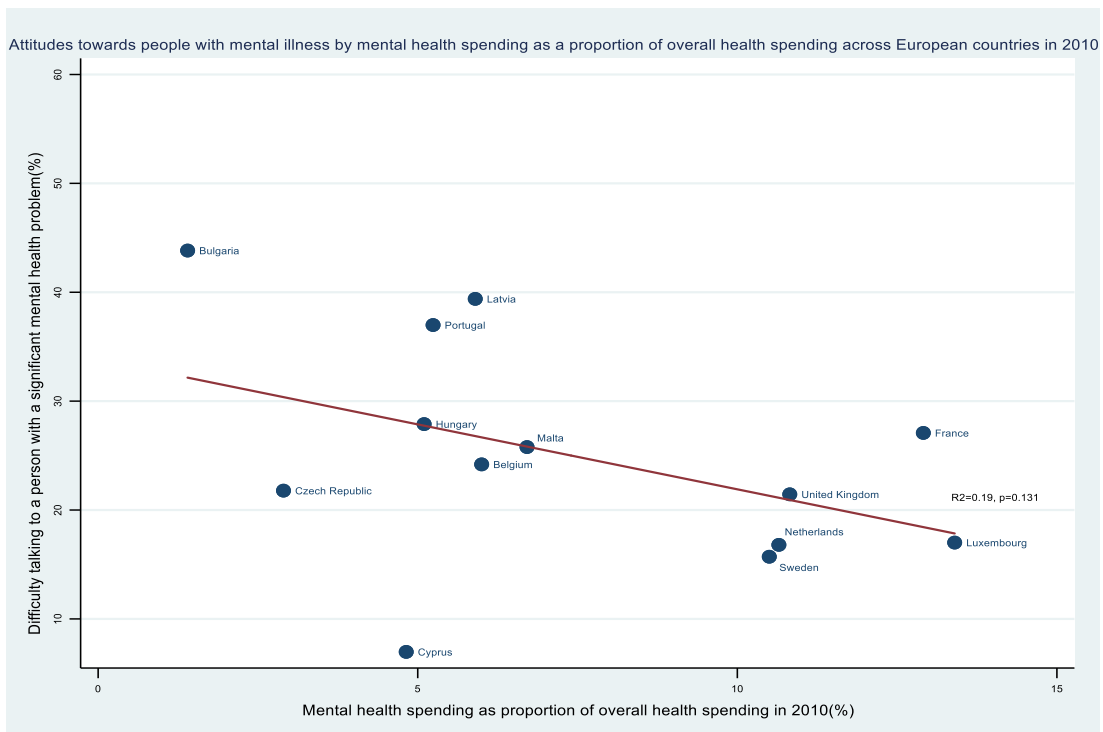
Proportion of respondents finding it difficult to talk to a person with mental illness by income inequality across the EU27



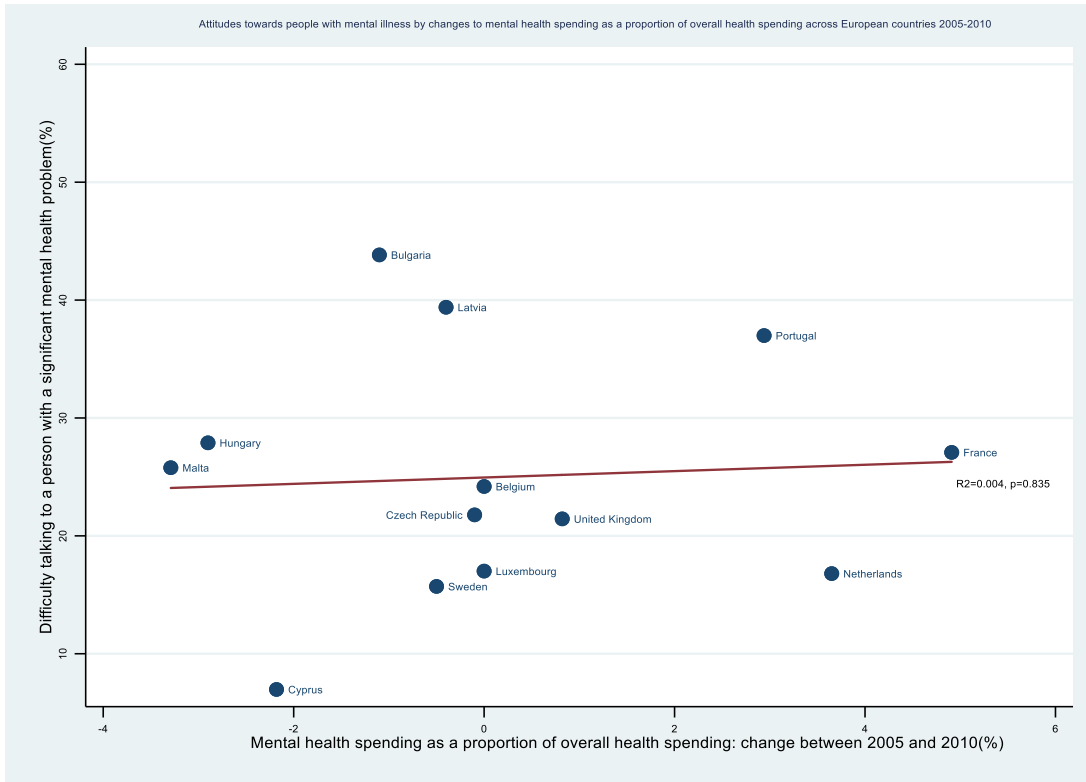
Proportion of respondents finding it difficult to talk to a person with mental illness by country level disability poverty and social exclusion gap across the EU27



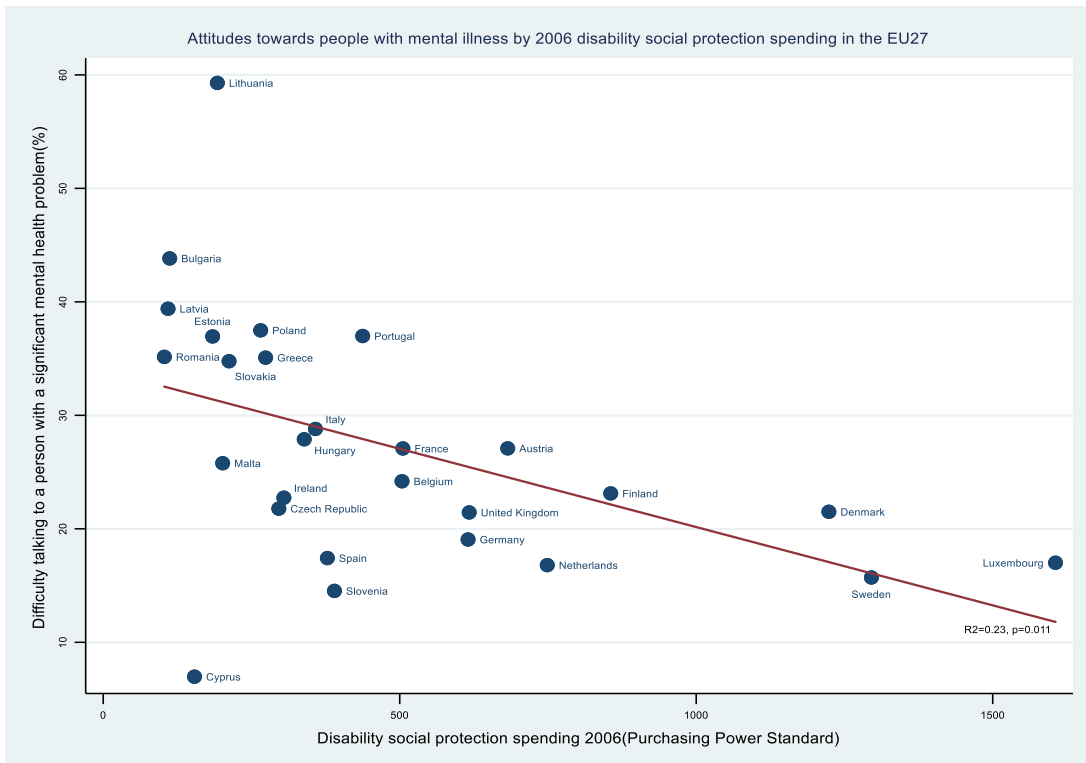
Proportion of respondents finding it difficult to talk to a person with mental illness by country level mental health spending as a proportion of overall health spending across European countries (2005)



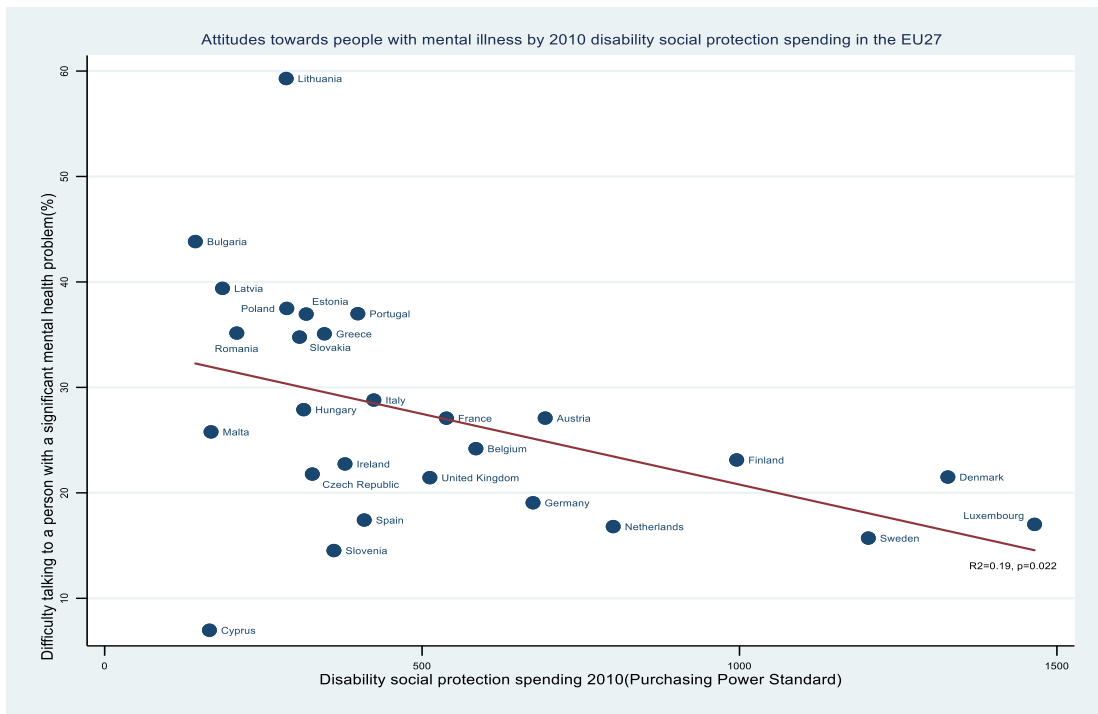
Proportion of respondents finding it difficult to talk to a person with mental illness by country level mental health spending as a proportion of overall health spending across European countries (2010)



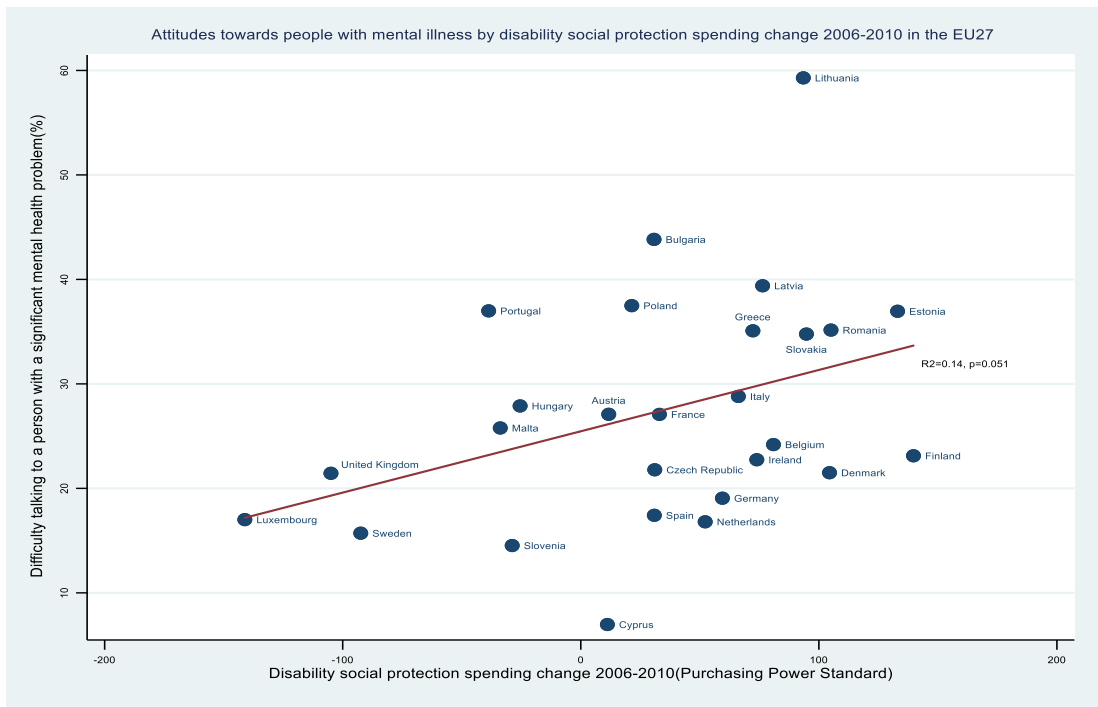
Proportion of respondents finding it difficult to talk to a person with mental illness by country level mental health spending change (2005-2010) across European countries



Proportion of respondents finding it difficult to talk to a person with mental illness by country level disability protection spending across the EU27 (2006)



Proportion of respondents finding it difficult to talk to a person with mental illness by country level disability protection spending across the EU27 (2010)



Proportion of respondents finding it difficult to talk to a person with mental illness by country level disability protection spending change across the EU27 (2006-2010)

## Appendix 7: Comparison of logistic and multilevel logistic regression models (multilevel models highlighted in grey)

| Variable/Model                             | 2a(i)<br>N=10,591  | 2a(i)<br>N=10,591  | 2a(ii) N=10,591    | 2a(ii)<br>N=10,591 | 2a(iii)<br>N=10,591 | 2a(iii)<br>N=10,591 |
|--|--------------------|--------------------|--------------------|--------------------|---------------------|---------------------|
| Baseline                                   | 0.66(0.55-0.79)*** | 0.64(0.32-1.27)    | 0.69(0.58-0.83)*** | 0.59(0.30-1.14)    | 0.17(0.11-0.27)***  | 0.16(0.01-1.37)     |
| Difficulty paying bills never/almost never |                    |                    |                    |                    |                     |                     |
| From time to time                          | 1.37(1.23-1.52)*** | 1.19(1.07-1.33)**  | 1.28(1.15-1.43)*** | 1.19(1.07-1.33)**  | 1.26(1.13-1.40)***  | 1.19(1.07-1.33)**   |
| Most of the time                           | 1.82(1.58-2.10)*** | 1.49(1.28-1.73)*** | 1.66(1.43-1.91)*** | 1.49(1.28-1.73)*** | 1.57(1.35-1.81)***  | 1.49(1.28-1.73)***  |
| Age 16-25                                  |                    |                    |                    |                    |                     |                     |
| 26-39                                      | 0.77(0.66-0.90)**  | 0.80(0.69-0.94)**  | 0.79(0.67-0.92)**  | 0.80(0.69-0.94)**  | 0.81(0.69-0.94)**   | 0.80(0.69-0.94)**   |
| 40-54                                      | 0.68(0.58-0.79)*** | 0.70(0.60-0.82)*** | 0.70(0.60-0.82)*** | 0.70(0.60-0.82)*** | 0.72(0.61-0.84)***  | 0.70(0.60-0.82)***  |
| 55 years and above                         | 0.86(0.75-0.99)*   | 0.87(0.75-1.01)    | 0.88(0.76-1.01)    | 0.87(0.75-1.01)    | 0.90(0.78-1.04)     | 0.87(0.75-1.01)     |
| Male                                       |                    |                    |                    |                    |                     |                     |
| Female                                     | 0.82(0.75-0.90)*** | 0.81(0.74-0.89)*** | 0.82(0.75-0.89)*** | 0.81(0.74-0.88)*** | 0.82(0.75-0.89)***  | 0.81(0.74-0.89)***  |
| Mental health spending 2005                | 0.92(0.91-0.94)*** | 0.92(0.85-1.00)    | 0.98(0.96-1.00)    | 0.98(0.87-1.11)    | 0.98(0.96-1.00)     | 0.99(0.88-1.11)     |
| Mental health spending change 2005-2010    | 1.00(0.98-1.02)    | 1.01(0.90-1.14)    | 1.05(1.03-1.08)*** | 1.06(0.93-1.21)    | 1.03(1.01-1.06)**   | 1.05(0.93-1.19)     |
| Income inequality (Gini)                   |                    |                    |                    |                    | 1.04(1.03-1.05)***  | 1.04(0.97-1.11)     |
| GDP per capita (Euros)                     |                    |                    | 0.99(0.99-0.99)*** | 0.99(0.99-1.00)    | 0.99(0.99-0.99)***  | 0.99(0.99-1.00)     |
| LR Test                                    |                    | 238.08***          |                    | 174.09***          |                     | 126.89***           |
| ICC  |                    | 0.06(0.02-0.14)    |                    | 0.05(0.02-0.12)    |                     | 0.05(0.02-0.11)     |



## Comparison of logistic and multilevel logistic regression models continued

| Variable/Model                             | 2c(i)<br>N=23,427  | 2c(i)<br>N=23,427  | 2c(ii)<br>N=23,427 | 2c(ii)<br>N=23,427 | 2c(iii)<br>N=23,427 | 2c(iii)<br>N=23,427 |
|--|--------------------|--------------------|--------------------|--------------------|---------------------|---------------------|
| Baseline                                   | 0.39(0.35-0.44)*** | 0.45(0.24-0.82)**  | 0.81(0.70-0.94)**  | 0.90(0.48-1.68)    | 0.12(0.09-0.17)***  | 0.12(0.03-0.51)***  |
| Difficulty paying bills never/almost never |                    |                    |                    |                    |                     |                     |
| From time to time                          | 1.49(1.40-1.59)*** | 1.25(1.17-1.34)*** | 1.28(1.19-1.37)*** | 1.25(1.17-1.34)*** | 1.24(1.16-1.32)***  | 1.25(1.16-1.34)***  |
| Most of the time                           | 1.98(1.80-2.18)*** | 1.53(1.38-1.70)*** | 1.63(1.48-1.80)*** | 1.52(1.37-1.69)*** | 1.51(1.37-1.67)***  | 1.52(1.37-1.69)***  |
| Age 16-25                                  |                    |                    |                    |                    |                     |                     |
| 26-39                                      | 0.86(0.78-0.95)**  | 0.88(0.80-0.98)*   | 0.87(0.79-0.97)**  | 0.88(0.80-0.98)*   | 0.89(0.80-0.99)*    | 0.88(0.80-0.98)*    |
| 40-54                                      | 0.79(0.71-0.87)*** | 0.82(0.73-0.91)*** | 0.82(0.74-0.91)*** | 0.82(0.74-0.91)*** | 0.84(0.75-0.93)**   | 0.82(0.74-0.91)***  |
| 55 years and above                         | 0.91(0.83-1.01)    | 0.97(0.88-1.07)    | 0.96(0.87-1.05)    | 0.97(0.88-1.08)    | 0.99(0.89-1.09)     | 0.97(0.88-1.08)     |
| Male                                       |                    |                    |                    |                    |                     |                     |
| Female                                     | 0.83(0.78-0.88)*** | 0.81(0.77-0.87)*** | 0.82(0.77-0.87)*** | 0.81(0.77-0.86)*** | 0.83(0.78-0.88)***  | 0.81(0.77-0.87)***  |
| Poverty and social exclusion gap           | 0.99(0.99-1.00)    | 0.98(0.93-1.03)    | 0.98(0.97-0.99)**  | 0.96(0.92-1.00)    | 0.97(0.97-0.98)***  | 0.96(0.92-0.99)*    |
| Income inequality (Gini)                   |                    |                    |                    |                    | 1.06(1.05-1.07)***  | 1.06(1.02-1.11)**   |
| GDP per capita (Euros)                     |                    |                    | 0.99(0.99-0.99)*** | 0.99(0.99-0.99)*** | 0.99(0.99-0.99)***  | 0.99(0.99-0.99)**   |
| LR test                                    |                    | 986.18***          |                    | 593.88***          |                     | 401.86***           |
| ICC  |                    | 0.08 (0.04-0.13)   |                    | 0.05 (0.03-0.09)   |                     | 0.04 (0.02-0.07)    |

## Comparison of logistic and multilevel logistic regression models continued

| Variable/Model                             | 2d(i)<br>N=23,427  | 2d(i)<br>N=23,427  | 2d(ii)<br>N=23,427 | 2d(ii)<br>N=23,427 |
|--|--------------------|--------------------|--------------------|--------------------|
| Baseline                                   | 0.03(0.02-0.04)*** | 0.03(0.00-0.14)*** | 0.10(0.08-0.14)*** | 0.09(0.02-0.39)**  |
| Difficulty paying bills never/almost never |                    |                    |                    |                    |
| From time to time                          | 1.35(1.26-1.44)*** | 1.25(1.17-1.34)*** | 1.24(1.16-1.32)*** | 1.25(1.16-1.34)*** |
| Most of the time                           | 1.64(1.49-1.82)*** | 1.52(1.37-1.69)*** | 1.49(1.35-1.64)*** | 1.52(1.37-1.68)*** |
| Age 16-25                                  |                    |                    |                    |                    |
| 26-39                                      | 0.89(0.80-0.98)**  | 0.88(0.80-0.98)*   | 0.90(0.81-0.99)*   | 0.89(0.80-0.98)*   |
| 40-54                                      | 0.82(0.74-0.91)*** | 0.82(0.74-0.91)*** | 0.84(0.76-0.93)**  | 0.82(0.74-0.91)*** |
| 55 years and above                         | 0.97(0.88-1.06)    | 0.97(0.88-1.08)    | 0.99(0.89-1.09)    | 0.97(0.88-1.08)    |
| Male                                       |                    |                    |                    |                    |
| Female                                     | 0.83(0.78-0.88)*** | 0.81(0.77-0.87)*** | 0.82(0.78-0.87)*** | 0.81(0.77-0.87)*** |
| Income inequality (Gini)                   | 1.08(1.07-1.09)*** | 1.08(1.03-1.13)**  | 1.05(1.05-1.06)*** | 1.06(1.01-1.10)*   |
| GDP per capita (Euros)                     |                    |                    | 0.99(0.99-0.99)*** | 0.99(0.99-0.99)*   |
| LR test                                    |                    | 605.34***          |                    | 424.23***          |
| ICC  |                    | 0.05 (0.03-0.09)   |                    | 0.04 (0.02-0.08)   |

## Bibliography

Abdul-Hamid, W. K. and Bhui, K. (2014). Psychiatry, homeless patients and welfare reforms: Historical links and chains. *International Journal of Social Psychiatry*, 60(1), 71-74.

Adjaye-Gbewonyo, K. and Kawachi, I. (2012). Use of the Yitzhaki Index as a test of relative deprivation for health outcomes: A review of recent literature. *Social Science & Medicine*, 75(1), 129-137.

Adler, N. and Ostrove, J. (1999). Socioeconomic status and health: What we know and what we don't. *Socioeconomic Status And Health In Industrial Nations*, 896, 3-15.

Adler, N. E., Epel, E.S., Castellazzo, G. and Ickovics, J.R. (2000). Relationship of Subjective and Objective Social Status With Psychological and Physiological Functioning: Preliminary Data in Healthy White Women. *Health Psychology*, 19(6), 586-592.

Adriaanse, M., Veling, W., Doreleijers, T. and Domburgh, L. (2014). The link between ethnicity, social disadvantage and mental health problems in a school-based multiethnic sample of children in the Netherlands. *European Child & Adolescent Psychiatry*, 23(11), 1103-1113.

Agerbo, E., Mortensen, P., Eriksson, P., Qin, P. and Westergaard-Nielsen, N. (2001). Risk of Suicide In Relation to Income Level In People Admitted to Hospital With Mental Illness: Nested Case-Control Study. *British Medical Journal*, 322(7282), 334-335.

Agerbo, E., Qin, P. and Mortensen, P. (2006). Psychiatric illness, socioeconomic status, and marital status in people committing suicide: a matched case-sibling-control study. *Journal Of Epidemiology And Community Health*, 60(9), 776-781.

Albor, C., Uphoff, E.P., Stafford, M., Ballas, D., Wilkinson, R.G. and Pickett, K.E. (2014). The effects of socioeconomic incongruity in the neighbourhood on social support, self-esteem and mental health in England. *Social Science & Medicine*, 111, 1-9.

Albrekt Larsen, C. and Dejgaard, T.E. (2013). The institutional logic of images of the poor and welfare recipients: A comparative study of British, Swedish and Danish newspapers. *Journal of European Social Policy*, 23(3), 287-299.

Alexander, L. and Link, B. (2003). The impact of contact on stigmatizing attitudes toward people with mental illness. *Journal of Mental Health*, 12(3), 271-289.

Angermeyer, M. C., Beck, M. and Matschinger, H. (2003). Determinants of the Public's Preference for Social Distance from People with Schizophrenia. *The Canadian Journal of Psychiatry*, 48(10), 663-668.

Angermeyer, M. C. and Matschinger, H. (2003). The stigma of mental illness: effects of labelling on public attitudes towards people with mental disorder. *Acta Psychiatrica Scandinavica*, 108(4), 304-309.

Angermeyer, M. C., Matschinger, H., Carta, M.G. and Schomerus, G. (2014a). Changes in the perception of mental illness stigma in Germany over the last two decades. *European psychiatry : the journal of the Association of European Psychiatrists*, 29(6), 390-395.

Angermeyer, M. C., Millier, A., Kouki, M. Refai, T. Schomerus, G. and Toumi, M. (2014b). Biogenetic explanations and emotional reactions to people with schizophrenia and major depressive disorder. *Psychiatry Research*, 220(1-2), 702-704.

Aslund, C., Starrin, B. and Nilsson, K.W. (2014). Psychosomatic symptoms and low psychological well-being in relation to employment status: the influence of social capital in a large cross-sectional study in Sweden. *International Journal of Equity in Health*, 13(22), 1-10.

ATOS Independent Assessment Services (2018). Written evidence. In House of Commons Work and Pensions Committee, 2018. PIP and ESA assessments: claimant experiences. Fourth Report of Session 2017-19. [online] Available at: <http://data.parliament.uk/WrittenEvidence/CommitteeEvidence.svc/EvidenceDocument/Work%20and%20Pensions/PIP%20and%20ESA%20assessments/written/74067.html>. Accessed 03/04/2018.

Baert, S., De Visschere, S., Schoors, K., Vandenberghe, D. and Omey, E. (2016). First depressed, then discriminated against? *Social Science and Medicine*, 170, 247-254.

Bambra, C. (2008). Incapacity benefit reform and the politics of ill health. *British Medical Journal*, 337(7668), 517.

Ban, L., Gibson, J.E., West, J., Fiaschi, L., Oates, M.R. and Tata, L.J. (2012). Impact of socioeconomic deprivation on maternal perinatal mental illnesses presenting to UK general practice. *British Journal of General Practice*, 62(603), 671-678.

Banks, J., Blundell, R. and Emmerson, C. (2015). Disability Benefit Receipt and Reform: Reconciling Trends in the United Kingdom. *Journal of Economic Perspectives*, 29(2), 173-190.

Barr, B., Kinderman, P. and Whitehead, M. (2015a). Trends in mental health inequalities in England during a period of recession, austerity and welfare reform 2004 to 2013. *Social Science and Medicine*, 147, 324-331.

Barr, B., et al. (2015b). 'First do no harm': are disability assessments associated with adverse trends in mental health? A longitudinal ecological study. *Journal of Epidemiology & Community Health*, 1-7.

Baumberg, B. (2016). The stigma of claiming benefits: a quantitative study. *Journal of Social Policy*, 45(2), 181-199.

Baumberg-Geiger (2017). *Sharp softening of attitudes to benefit claimants, reveals new data*. [online] Available at: <http://natcen.ac.uk/blog/sharp-softening-of-attitudes-to-benefit-claimants,-reveals-new-data>. Accessed 06/2018.

Ben-Ishai, E. (2012). The New Paternalism. *Political Research Quarterly*, 65(1), 151-165.

Beresford, P. (2016). Presenting welfare reform: poverty porn, telling sad stories or achieving change? *Disability & Society*, 31(3), 421-425.

Bhaskar, R. (1975). *A realist theory of science*, York: Books.

Bianchi, E. C., Hall, E. V. and Lee, S. (2018). Re-examining the Link Between Economic Downturns and Racial Antipathy: Evidence That Prejudice Against Blacks Rises During Recessions. *Psychological Science*, 29(10), 1584-1597.

Bos, A. R., Pryor, J., Reeder, G. and Stutterheim, S. (2013). Stigma: Advances in Theory and Research. *Basic and Applied Social Psychology*, 35(1), 1-9.

Bourdieu, P. (1991). *Language and symbolic power*, Cambridge, Massachusetts: Polity Press.

Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.

Briant, E., Watson, N. and Philo, G. (2013). Reporting Disability in the Age of Austerity: The Changing Face of Media Representation of Disability and Disabled People in the United Kingdom and the Creation of New 'Folk Devils'. *Disability & Society*, 28(6), 874-889.

British Psychological Society (2011). Response to the American Psychiatric Association DSM-5 Development. [online] Available at: [http://apps.bps.org.uk/\\_publicationfiles/consultation-responses/DSM-5%202011%20-%20BPS%20response.pdf](http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5%202011%20-%20BPS%20response.pdf). Accessed 08/2018.

Brown, A. S., Susser, E.S., Jandorf, L. and Bromet, E.J. (2000). Social class of origin and cardinal symptoms of schizophrenic disorders over the early illness course. *Social Psychiatry and Psychiatric Epidemiology*, 35(2), 53-60.

Brown, B. J. and Baker, S. (2012). *Responsible Citizens : Individuals, Health, and Policy Under Neoliberalism*, New York: Anthem Press.

Bryan, M. L. and Jenkins, S. P. (2016). Multilevel Modelling of Country Effects: A Cautionary Tale. *European Sociological Review*, 32(1), 3-22.

Burchardt, T. (1999). *The evolution of disability benefits in the UK: re-weighting the basket*. London: London School of Economics.

- Burns, J. K., Tomita, A. and Kapadia, A. S. (2014). Income inequality and schizophrenia: Increased schizophrenia incidence in countries with high levels of income inequality. *International Journal of Social Psychiatry*, 60(2), 185-196.
- Businelle, M. S., Mills, B.A., Chartier, K.G., Kendzoe, D.E., Reingle, J.M. and Shuval, K. (2014). Do stressful events account for the link between socioeconomic status and mental health? *Journal of Public Health*, 36(2), 205-212.
- Callanan, C. (2011). How welfare changes will affect people with mental health problems: the government has released plans to reduce the number of people who claim disability benefits by restricting their eligibility. But, asks Charlie Callanan, will they work? *Mental Health Practice*, 15(2), 34.
- Campellone, T. R. (2014). Treating the cause, not the symptoms, of mental illness stigma. *The Lancet Psychiatry*, 1(2), 96.
- Campos-Matos, I. and Kawachi, I. (2015). Social mobility and health in European countries: Does welfare regime type matter? *Social Science & Medicine*, 142, 241-248.
- Carpenter, M. (2009). A Third Wave, Not a Third Way? New Labour, Human Rights and Mental Health in Historical Context. *Social Policy and Society*, 8(2), 215-230.
- Case, A. and Deaton, A. (2015). Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century. *Proceedings of the National Academy of Sciences of the United States of America*, 112(49), 15078-15083.
- Charmaz, K. (1991). *Good days, bad days : the self in chronic illness and time*, New Brunswick, New Jersey: Rutgers University Press.
- Clarke, J. and Gawley, A. (2009). The Triumph of Pharmaceuticals: The Portrayal of Depression from 1980 to 2005. *Administration and Policy in Mental Health and Mental Health Services Research*, 36(2), 91-101.
- Cornelis, I., Van Hiel, A., Roets, A. and Kossowska, M. (2009). Age Differences in Conservatism: Evidence on the Mediating Effects of Personality and Cognitive Style. *Journal of Personality*, 77(1), 51-88.
- Corrigan, P. W. (2016). Lessons learned from unintended consequences about erasing the stigma of mental illness. *World Psychiatry*, 15(1), 67-73.
- Corrigan, P. W., Markowitz, F. E. and Watson, A. C. (2004). Structural Levels of Mental Illness Stigma and Discrimination. *Schizophrenia Bulletin*, 30(3), 481-491.
- Corrigan, P. W., Rafacz, J. and Rüsich, N. (2011). Examining a progressive model of self-stigma and its impact on people with serious mental illness. *Psychiatry Research*, 189(3), 339-343.

Corrigan, W. P., et al. (2016). Who Comes Out With Their Mental Illness and How Does It Help? *The Journal of Nervous and Mental Disease*, 204(3), 163-168.

Cross, M. (2013). Demonised, impoverished and now forced into isolation: the fate of disabled people under austerity. *Disability & Society*, 28(5), 719-723.

Curnock, E., Leyland, A. and Popham, F. (2016). The impact on health of employment and welfare transitions for those receiving out-of-work disability benefits in the UK. *Social Science & Medicine*, 162, 1-10.

Daly, M., Boyce, C. and Wood, A. (2015). A Social Rank Explanation of How Money Influences Health. *Health Psychology*, 34(3), 222-230.

Danermark, B. (2002). *Explaining society : critical realism in the social sciences*, New York: Routledge.

Dear, M. J. and Wolch, J. R. (1987). *Landscapes of despair : from deinstitutionalization to homelessness*, Cambridge, UK: Polity Press.

Department for Communities and Local Government (2016). *English Housing Survey: Social Rented Sector Report 2014-15*. London: Crown.

Department of Health and Social Care (2011). *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*. London: HM Government.

Department for Work and Pensions (2011). Government's response to the consultation on Disability Living Allowance reform. [online] Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/181637/dla-reform-response.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/181637/dla-reform-response.pdf). Accessed 03/2018.

Department of Work and Pensions (2016). Work, Health and Disability Green Paper: Improving Lives. [online] Available at: <https://www.gov.uk/government/consultations/work-health-and-disability-improving-lives>. Accessed 22/05/2017.

Department for Work and Pensions (2016). Disability Living Allowance and Personal Independence Payment: the main differences. [online] Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/516961/main-differences-between-disability-living-allowance-and-personal-independence-payment-leaflet.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/516961/main-differences-between-disability-living-allowance-and-personal-independence-payment-leaflet.pdf). Accessed 03/04/2018.

Department for Work and Pensions, Department of Health (2017). Improving Lives: The Future of Work, Health and Disability. [online] Available at: <https://www.gov.uk/government/publications/improving-lives-the-future-of-work-health-and-disability>. Accessed 10/2018.

Department for Work and Pensions (2018). Welfare: Written statement – HCWS414. [online] Available at: <https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2018-01-19/HCWS414/>. Accessed 03/04/2018.

Dinos, S. (2014). Stigma creating stigma: a vicious circle. *Psychiatric bulletin* (2014), 38(4), 145-147.

Dohrenwend, B. P., et al. (1992). Socioeconomic Status and Psychiatric Disorders: The Causation-Selection Issue. *Science*, 255(5047), 946-952.

Dorling, D. (2015). *Injustice : why social inequality still persists, 2nd ed.* Bristol: Policy Press.

Dwyer, P. (2004). *Understanding social citizenship: Themes and perspectives for policy and practice. 2<sup>nd</sup> Edition.* Bristol: The Policy Press.

Dwyer, P. (2004). Creeping Conditionality in the UK: From Welfare Rights to Conditional Entitlements? *The Canadian Journal of Sociology*, 29(2), 265-287.

Dwyer, P., Jones, K., McNeill, J., Scullion, L. and Stewart, A. (2016). First Wave Findings: Disability and Conditionality. [online] Available at: <http://www.welfareconditionality.ac.uk/wp-content/uploads/2016/05/WelCond-findings-disability-May16.pdf>. Accessed 01/10/2017

Dwyer, P. (2016). Citizenship, conduct and conditionality: sanction and support in the 21<sup>st</sup>-century UK welfare state. *Social Policy Review*. Bristol: The Policy Press.

Dwyer, P. (2017). Rewriting the contract? Conditionality, welfare reform and the rights and responsibilities of disabled people. *In Social Policy in an era of competition: from global to local perspectives.* Eds. Horsfall, D. and Hudson, J. Bristol: The Policy Press.

Dwyer, P., Jones, K., McNeill, J., Scullion, L. and Stewart, A. (2018). Final findings: Disabled people. [online] Available at: <http://www.welfareconditionality.ac.uk/wp-content/uploads/2018/05/40414-Disabled-people-web.pdf>. Accessed 11/2018.

Dwyer, P. (2018). Punitive and ineffective: benefit sanctions within social security. *Journal of Social Security Law*, 142-157.

Eaton, V., et al. (2011). Mental Health and Wellbeing in Leeds: An Assessment of Need in the Adult Population. NHS Leeds.

Elliot, I. (2016). *Poverty and Mental Health: A review to inform the Joseph Rowntree Foundation's Anti-Poverty Strategy.* London: Mental Health Foundation.

Elliot, M., Fairweather, I., Olsen, W. and Pampaka, M. (2016). Retrodution. *A Dictionary of Social Research Methods*, Oxford University Press.



Esposito, L. and Perez, F. M. (2014). Neoliberalism and the Commodification of Mental Health. *Humanity & Society*, 38(4), 414-442.

Euteneuer, F. (2014). Subjective social status and health. *Current Opinion in Psychiatry*, 27(5), 337-343.

Eurobarometer (2010). *Special Eurobarometer 345: Mental Health*. [online]

Available at:

[http://ec.europa.eu/commfrontoffice/publicopinion/archives/ebs/ebs\\_345\\_en.pdf](http://ec.europa.eu/commfrontoffice/publicopinion/archives/ebs/ebs_345_en.pdf).

Accessed 02/2018.

Eurostat (2018). Data database. [online] Available at:

<https://ec.europa.eu/eurostat/data/database>. Accessed 01/2018

Evans-Lacko, S., Brohan, E., Mojtabai, R. and Thornicroft, G. (2012). Association between public views of mental illness and self-stigma among individuals with mental illness in 14 European countries. *Psychological Medicine*, 42(8), 1741-1752.

Evans-Lacko, S., Knapp, M., McCrone, P., Thornicroft, G. and Mojtabai, R. (2013). The Mental Health Consequences of the Recession: Economic Hardship and Employment of People with Mental Health Problems in 27 European Countries. *PLoS One*, 8(7), e69792.

Evans-Lacko, S., Corker, E., Williams, P., Henderson, C. and Thornicroft, G. (2014). Effect of the Time to Change anti-stigma campaign on trends in mental-illness-related public stigma among the English population in 2003-13: an analysis of survey data. *The Lancet Psychiatry*, 1(2), 121-128.

Farrelly, S., Jeffrey, D., Rusch, N., Williams, P., Thornicroft, G. and Clement, S. (2015). The link between mental health-related discrimination and suicidality: service user perspectives. *Psychological Medicine*, 45(10), 2013-2022.

Fletcher, A. J. (2017). Applying critical realism in qualitative research: methodology meets method. *International Journal of Social Research Methodology*, 20(2), 181-194.

Foucault, M. (1967). *Madness and civilization : a history of insanity in the Age of Reason*, London: Tavistock Publications.

Furnham, A., Lee, V. and Kolzeev, V. (2015). Mental health literacy and borderline personality disorder (BPD): what do the public "make" of those with BPD?(Report). *Social Psychiatry and Psychiatric Epidemiology*, 50(2), 317-324.

Full Fact (2017). Are people with mental health conditions now receiving higher disability benefit payments? [online] Available at: <https://fullfact.org/economy/are-people-mental-health-conditions-now-receiving-higher-disability-benefit-payments/>. Accessed 06/2018.

- Gajwani, R., Parsons, H., Birchwood, M. and Singh, S.P. (2016). Ethnicity and detention: are Black and minority ethnic (BME) groups disproportionately detained under the Mental Health Act 2007? *Social Psychiatry and Psychiatric Epidemiology*, 51(5), 703-711.
- Garthwaite, K. (2011). 'The language of shirkers and scroungers?' Talking about illness, disability and coalition welfare reform. *Disability & Society*, 26(3), 369-372.
- Garthwaite, K. (2014). Fear of the Brown Envelope: Exploring Welfare Reform with Long-Term Sickness Benefits Recipients. *Social Policy & Administration*, 48(7), 782-798.
- Garthwaite, K. (2015). Becoming incapacitated? Long term sickness benefit recipients and the construction of stigma and identity narratives. *Sociology of Health & Illness*, 37(1), 1-13.
- Giatti, L., Camelo, L.D.V., Rodrigues, J.F. and Barreto, S.M. (2012). Reliability of the MacArthur scale of subjective social status - Brazilian Longitudinal Study of Adult Health (ELSA-Brasil). *BMC Public Health*, 12, 1096.
- Gift, T. E., et al. (1986). Social class and psychiatric outcome. *The American Journal of Psychiatry*, 143(2), 222-225.
- Gilbert, P. and Miles, J. (2002). *Body shame : conceptualisation, research, and treatment*, Hove, East Sussex: Brunner-Routledge.
- Glover-Thomas, N. (2002). *Reconstructing mental health law and policy*. Edinburgh: Reed Elsevier (UK) Ltd.
- Goffman, E. (1963). *Stigma : notes on the management of spoiled identity*, Englewood Cliffs, New Jersey: Prentice-Hall.
- Goffman, E. (1968). *Asylums : essays on the social situation of mental patients and other inmates*, Harmondsworth: Penguin.
- Gov.uk. (2016). *Council Housing* [Online]. Available at: <https://www.gov.uk/council-housing>. Accessed 08/09/2016.
- Gov.uk (2016). Employment and Support Allowance sanctions: how to keep your benefit payment. [Online]. Available at: <https://www.gov.uk/government/publications/employment-and-support-allowance-sanctions/employment-and-support-allowance-sanctions-how-to-keep-your-benefit-payment>. Accessed 17/03/19
- Gov.uk. (2018). Personal Independence Payments. [online] Available at: <https://www.gov.uk/pip>. Accessed 03/2018.
- Gov.uk. (2018). Jobseekers Allowance. [online] Available at: <https://www.gov.uk/jobseekers-allowance/your-jsa-claim>. Accessed 13/11/2018.

Grant, A. and Gadsby, J. (2018). The Power Threat Meaning Framework and international mental health education: A welcome revolution in human rights. *Nurse Education Today*, 68, 1-3.

Gray P. (2017). The Second Independent Review of the Personal Independence Payment Assessment. [online] Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/604097/pip-assessment-second-independent-review.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/604097/pip-assessment-second-independent-review.pdf). Accessed 06/2018.

Gray, M. and Barford, A. (2018). The depths of the cuts: the uneven geography of local government austerity. *Cambridge Journal of Regions, Economy and Society*, 11(3), 541-563.

Grover, C. and Piggott, L. (2015). A right not to work and disabled people. In *Disabled people, work and welfare*. Bristol: Policy Press.

Hamnett, C. (2014). Shrinking the welfare state: the structure, geography and impact of British government benefit cuts. *Transactions of the Institute of British Geographers*, 39, 490-503.

Hanandita, W. and Tampubolon, G. (2014). Does poverty reduce mental health? An instrumental variable analysis. *Social Science & Medicine*, 113, 59-67.

Hansen, H., Bourgois, P. and Drucker, E. (2013). Pathologizing poverty: New forms of diagnosis, disability, and structural stigma under welfare reform. *Social Science & Medicine*, 103, 76-83.

Hatzenbuehler, M. L. and Link, B. G. (2014). Introduction to the special issue on structural stigma and health. *Social Science & Medicine*, 103, 1-6.

Henderson, C., Evans-Lacko, S., Flach, C. and Thornicroft, G. (2012). Responses to Mental Health Stigma Questions: The Importance of Social Desirability and Data Collection Method. *The Canadian Journal of Psychiatry*, 57(3), 152-160.

Hewlett, E. and Horner, K. (2015). Mental Health Analysis Profiles (MhAPs): England. *OECD Health Working Papers*. Paris.

Hirst, M. A. and Sainsbury, R. (1996). *Social security and mental health: the impact of Disability Living Allowance*, York: Social Policy Research Unit.

Historic England (2018). From Bethlehem to Bedlam – England’s First Mental Institution. [online] Available at: <https://historicengland.org.uk/research/inclusive-heritage/disability-history/1050-1485/from-bethlehem-to-bedlam/>. Accessed 03/2018.

Hollingshead, A. D. B. (1958). *Social class and mental illness : a community study*, New York: John Wiley & Sons.

Home Office (2017). Hate Crime, England and Wales, 2016/17. London: Crown.

House of Commons Work and Pensions Committee. PIP and ESA assessments: claimant experiences. Fourth Report of Session 2017-19. [online] Available at: <https://publications.parliament.uk/pa/cm201719/cmselect/cmworpen/355/355.pdf>. Accessed 03/04/2018.

Huline-Dickens, S. (2013). The mental state examination. *Advances in Psychiatric Treatment*, 19, 97-98.

Hunter, C. (2007). Denying the severity of mental health problems to deny rights to the homeless. *People, Place & Policy Online*, 2(1), 17-27.

Hunter, P. (2014). Poverty in Suburbia: A Smith Institute Study into the Growth of Poverty in the Suburbs of England and Wales. London.

Johnson, S., Wibbels, E. and Wilkinson, R. (2015). Economic inequality is related to cross-national prevalence of psychotic symptoms. *Social Psychiatry and Psychiatric Epidemiology*, 50(12), 1799-1807.

Johnston, D. and Lordan, G. (2016). Racial prejudice and labour market penalties during economic downturns. *European Economic Review*, 84(C), 57-75.

Johnston, R. B. and Smith, S. P. (2010). *How critical realism clarifies validity issues in theory-testing research: analysis and case*. Canberra: ANU E Press.

Johnstone, I. and Boyle, M. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society.

Joint Public Issues Team (2015). Rethink Sanctions. [online]. Available at: <http://www.jointpublicissues.org.uk/resources/rethinksanctions/>. Accessed 25/04/2017.

Kelly, B. D. (2006). The power gap: Freedom, power and mental illness. *Social Science and Medicine*, 63, 2118-2128.

Kennedy, S. (2011). Disability Living Allowance Reform. Commons Briefing papers SN05869. House of Commons.

Kloos, B. and Townley, G. (2011). Investigating the Relationship Between Neighborhood Experiences and Psychiatric Distress for Individuals with Serious Mental Illness. *Administration and Policy in Mental Health and Mental Health Services Research*, 38(2), 105-116.

Kvaale, E. P., Haslam, N. and Gottdiener, W. H. (2013). The 'side effects' of medicalization: A meta-analytic review of how biogenetic explanations affect stigma. *Clinical Psychology Review*, 33(6), 782-794.

- Laing, R. D. (1960). *The divided self: a study of sanity and madness*, London: Tavistock.
- Lasalvia, A., et al. (2015). Cross-national variations in reported discrimination among people treated for major depression worldwide: the ASPEN/INDIGO international study. *The British Journal of Psychiatry*, 207(6), 507-514.
- Lawler, S. (2005). Disgusted subjects: The making of middle-class identities. *The Sociological Review*, 53(3), 429-446.
- Layte, R. (2012). The Association Between Income Inequality and Mental Health: Testing Status Anxiety, Social Capital, and Neo-Materialist Explanations. *European Sociological Review*, 28(4), 498-511.
- Leeds Observatory (2018). [online] Available at; <https://observatory.leeds.gov.uk/population/>. Accessed 03/2016.
- Link, B. and Phelan, J. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363-385.
- Link, B. G. and Phelan, J. (2013). Stigma power. *Social Science & Medicine*, 103, 24-32.
- Livingston, J. D. (2013). Mental Illness-Related Structural Stigma: The Downward Spiral of Systemic Exclusion Final Report. Canada: Mental Health Commission of Canada.
- Loopstra, R. and Lalor, D. (2017). Financial insecurity, food insecurity, and disability: the profile of people receiving emergency food assistance from The Trussell Trust Foodbank Network in Britain. [online] Available at: [https://www.trusselltrust.org/wpcontent/uploads/sites/2/2017/07/OU\\_Report\\_final\\_01\\_08\\_online2.pdf](https://www.trusselltrust.org/wpcontent/uploads/sites/2/2017/07/OU_Report_final_01_08_online2.pdf). Accessed 10/06/2018.
- MacIntyre, A., Ferris, D., Goncalves, B. and Quinn, N. (2018). What has economics got to do with it? The impact of socioeconomic factors on mental health and the case for collective action. *Palgrave Communications*, 4(10), 1-10.
- Makowski, A. C., Mnich, E.E., Angermeyer, M.C. and Von Dem Knesebeck, O. (2016). Continuum beliefs in the stigma process regarding persons with schizophrenia and depression: results of path analyses. *PeerJ*, 4, e2360.
- Manji, K. (2017). Social Security Reform and the Surveillance State: Exploring the Operation of 'Hidden Conditionality' in the Reform of Disability Benefits Since 2010. *Social Policy and Society*, 16(2), 305-314.
- Marmot, M. G. (2010). *Fair society, healthy lives: the Marmot Review*. Institute of Health Equity: The Marmot Review.
- Marmot, M. G. and Smith, G. D. (1997). Socio-economic Differentials in Health. *Journal of Health Psychology*, 2(3), 283-296.

McEvoy, P. and Richards, D. (2006). A critical realist rationale for using a combination of quantitative and qualitative methods. *Journal of Research in Nursing*, 11(1), 66-78.

McGinty, E. E., Webster, D. W. and Barry, C. L. (2013). Effects of news media messages about mass shootings on attitudes toward persons with serious mental illness and public support for gun control policies. *American Journal of Psychiatry*, 170(5), 494-501.

McWade, B. (2016). Recovery-as-Policy as a form of neoliberal state making. *Intersectionalities*, 5(3), 62-81.

Meers, J. (2016). Shifting the Place of Social Security: Social Rights Under Austerity in the UK. In Civitarese Matteucci, S. and Halliday, S. (eds.) *The Fate of Social Rights in an Age of Austerity: Law and Legal Challenges within Europe*. Routledge.

Mental Health Act 1983/2007. London: W.J.Sharp.

Mental Health Foundation (2017). Stigma and Discrimination. [online] Available at: <https://www.mentalhealth.org.uk/a-to-z/s/stigma-and-discrimination>. Accessed 13/11/2018.

Mental Health Foundation (2018). Parity of Esteem. [online] Available at: <https://www.mentalhealth.org.uk/a-to-z/p/parity-esteem>. Accessed 13/11/2018.

Mental Health Foundation (2018). Mental health statistics: homelessness. [online] Available at: <https://www.mentalhealth.org.uk/statistics/mental-health-statistics-homelessness>. Accessed 14/11/2018.

Mind and Rethink Mental Illness (2013). *Attitudes to Mental Illness 2012 Research Report*. Time to Change.

Mind (2016). Over half of people with mental health problems have had their benefits cut in the move from DLA to PIP. <https://www.mind.org.uk/news-campaigns/news/over-half-of-people-with-mental-health-problems-have-had-their-benefits-cut-in-the-move-from-dla-to-pip#.WzIXBWMnZpg>. Accessed 09/2017.

Mind (2017). PIP ruling a ‘victory for people with mental health problems’, says Mind. [online] Available at: <https://www.mind.org.uk/news-campaigns/news/pip-ruling-a-victory-for-people-with-mental-health-problems-says-mind/#.Wn1ooOdBrIW>. Accessed 03/04/2018.

Minton, J. and Bailey, N. (2016). Cities will just be playgrounds for rich if poor keep being pushed to suburbs. *The Conversation*.

- Mohring, K. (2012). The fixed-effects approach as alternative to multilevel models for cross-national analysis. *Paper prepared for the 10<sup>th</sup> ESPAnet Conference, Edinburgh, 2012*. [online] Available at: [http://www.sps.ed.ac.uk/\\_\\_data/assets/pdf\\_file/0005/89420/Moehring\\_\\_Stream\\_2.pdf](http://www.sps.ed.ac.uk/__data/assets/pdf_file/0005/89420/Moehring__Stream_2.pdf). Accessed 04/04/2018.
- Moncrieff, J. and Viola, S. (2016). Claims for sickness and disability benefits owing to mental disorders in the UK: trends from 1995 to 2014. *BJPsych open*, 2(1), 18-24.
- Morris, J. (2011). Rethinking disability policy. Joseph Rowntree Foundation.
- Murphy, N. A., Fatoye, F. and Wibberley, C. (2013). The changing face of newspaper representations of the mentally ill. *Journal of Mental Health*, 22(3), 271-282.
- Nairn, S. (2012). A critical realist approach to knowledge: implications for evidence-based practice in and beyond nursing. *Nursing Inquiry*, 19(1), 6-17.
- National Audit Office (2016). Benefit Sanctions. [online] Available at: <https://www.nao.org.uk/report/benefit-sanctions/>. Accessed 17/03/19
- National Health Service and Community Care Act (1990). London: The Stationary Office Limited.
- Nelson, G. B., Kloos, B. and Ornelas, J. (eds.) (2014). *Community psychology and community mental health : towards transformative change*: Oxford University Press.
- Ngui, E. M., Khasakhala, L., Ndeti, D. and Weiss-Roberts, L. (2010). Mental disorders, health inequalities and ethics: A global perspective. *International review of psychiatry*, 22(3), 235-244.
- O'Brien, R. L. (2015). Monetizing illness: The influence of disability assistance priming on how we evaluate the health symptoms of others. *Social Science & Medicine*, 128, 31-35.
- OECD (2012). *Sick on the Job? Myths and Realities about Mental Health and Work*. Mental Health and Work: OECD Publishing.
- Office for National Statistics (2015). Chapter 5: Social Contact. *Life Opportunities Survey*. London: Crown.
- Pachankis, E. J., et al. (2015). Hidden from health: structural stigma, sexual orientation concealment, and HIV across 38 countries in the European MSM Internet Survey. *AIDS*, 29(10), 1239-1246.
- Patrick, R. (2012). All in it together? Disabled people, the coalition and welfare to work. *Journal of Poverty and Social Justice*, 20(3), 307-322.
- Patrick, R. A. (2017). *For whose benefit?: the everyday realities of welfare reform*. Bristol: Policy Press.

Pemberton, S., Fahmy, E., Sutton, E. and Bell, K. (2016). Navigating the stigmatised identities of poverty in austere times: Resisting and responding to narratives of personal failure. *Critical Social Policy*, 36(1), 21-37.

Phelan, J., Lucas, J., Ridgeway, C. and Taylor, C. (2014). Stigma, status, and population health. *Social Science & Medicine*, 103, 15-23.

Philo, C. (1997). Across the water: Reviewing geographical studies of asylums and other mental health facilities. *Health and Place*, 3(2), 73-89.

Pickett, K. E. and Wilkinson, R. G. (2010). Inequality: an underacknowledged source of mental illness and distress. *The British Journal of Psychiatry*, 197(6), 426-428.

Plano Clark, V. L. and Creswell, J. W. (2008). *The mixed methods reader*. London: Sage Publications.

Poole, R., Higgs, R. and Robinson, C. A. (2013). *Mental Health and Poverty*. United Kingdom: Cambridge University Press.

Prag, P., Mills, M. C. and Wittek, R. (2016). Subjective Socioeconomic Status and Health in Cross-National Comparison. *Social Science and Medicine*, 149, 84-92.

Prins, S. J., Bates, L.M., Keyes, K.M. and Muntaner, C. (2015). Anxious? Depressed? You might be suffering from capitalism: contradictory class locations and the prevalence of depression and anxiety in the USA. *Sociology of Health & Illness*, 37(8), 1352-1372

Public Health England (2018). *Wider Determinants of Health*. [online] Available at: <https://fingertips.phe.org.uk/profile/wider-determinants>. Accessed 09/2018.

Public Law Project (2017). High court finds 2017 Personal Independence Payment (PIP) Regulations unlawful. [online] Available at: <http://www.publiclawproject.org.uk/news/95/high-court-finds-2017-personal-independence-payment-pip-regulations-unlawful>. Accessed 03/04/2018.

Quinn, N. et al. (2014). Nature and impact of European anti-stigma depression programmes. *Health Promotion International*, 29(3), 403-413.

QSR International Pty Ltd. (2015). Nvivo qualitative data analysis software, version 11.

Randall, J., Thornicroft, G., Brohan, E., Kassam, A., Lewis-Holmes, E. and Mehta, N. (2012). Stigma and Discrimination. In Dudley, M., Silove, D. and Gale, F. Eds. (2012). *Mental Health and Human Rights*. Oxford: Oxford University Press.

Rao, D., Feinglass, J. and Corrigan, P. (2007). Racial and ethnic disparities in mental illness stigma. *Journal of Nervous and Mental Disease*, 195(12), 1020-1023.



- Rehman, H. and Owen, D. (2013). Mental health survey of ethnic minorities: Research report. ETHNOS Research and Consultancy. [online] Available at: [https://www.time-to-change.org.uk/sites/default/files/TTC\\_Final%20Report\\_ETHNOS\\_summary\\_1.pdf](https://www.time-to-change.org.uk/sites/default/files/TTC_Final%20Report_ETHNOS_summary_1.pdf). Accessed 13/11/2018.
- Repper, J. (2003). *Social inclusion and recovery : a model for mental health practice*, Edinburgh: Baillière Tindall.
- Rogers, A. (2003). *Mental health and inequality*, Basingstoke: Palgrave.
- Rogers, A. and Pilgrim, D. (2010). *Sociology of Mental Health and Illness*, Buckingham: Open University Press.
- Roulstone A. (2015). Personal Independence Payments, welfare reform and the shrinking disability category. *Disability and Society*, 30(5), 673-688.
- Royal Australian and New Zealand College of Psychiatrists (2016). Welfare reform and it's impact on those with mental illness. *Australasian Psychiatry*, 22(5), 513.
- Rüsch, N., Todd, A.R., Bodenhausen, G.V. and Corrigan, P.W. (2010). Biogenetic models of psychopathology, implicit guilt, and mental illness stigma. *Psychiatry Research*, 179(3), 328-332.
- Rustenbach, E. (2010). Sources of Negative Attitudes toward Immigrants in Europe: A Multi-Level Analysis. *International Migration Review*, 44(1), 53-77.
- Sadler, M. S., Kaye, K. and Vaughn, A. A. (2015). Competence and warmth stereotypes prompt mental illness stigma through emotions. *Journal Of Applied Social Psychology*, 45(11), 602-612.
- Samele, C., et al. (2001). Does socioeconomic status predict course and outcome in patients with psychosis? *Social Psychiatry and Psychiatric Epidemiology*, 36(12), 573-581.
- Shildrick, T., MacDonald, R., Furlong, A., Roden, J. and Crow, R. (2012). *Are 'cultures of worklessness' passed down the generations?* Cambridge: Joseph Rowntree Foundation.
- Schindler, V. P. and Kientz, M. (2013). Supports and barriers to higher education and employment for individuals diagnosed with mental illness. *Journal of Vocational Rehabilitation*, 39(1), 29-41.
- Schram, S. (2000). In the Clinic: The Medicalization of Welfare. *Social Text*, 18, 81-107.
- Schrecker, T. A. and Bamba, C. A. (2015). *How politics makes us sick : neoliberal epidemics*. Basingstoke: Palgrave Macmillan.

- Sechrist, G. and Stangor, C. (2007). When are intergroup attitudes based on perceived consensus information?: The role of group familiarity. *Social Influence*, 2(3), 211-235.
- Seeman, N., Tang, S., Brown, A.D. and Ing, A. (2016). World survey of mental illness stigma. *Journal of affective disorders*, 190, 115-121.
- Shannon-Baker, P. (2016). Making Paradigms Meaningful in Mixed Methods Research. *Journal of Mixed Methods Research*, 10(4), 319-334.
- Sheehan, L., Nieweglowski, K. and Corrigan, P. (2016). The Stigma of Personality Disorders. *Current Psychiatry Reports*, 18(1), 1-7.
- Shefer, G., Henderson, C., Frost-Gaskin, M. and Pacitti, R. (2016). Only Making Things Worse: A Qualitative Study of the Impact of Wrongly Removing Disability Benefits from People with Mental Illness. *Community Mental Health Journal*, 52(7), 834-841.
- Sheffield City Council (2012). Planning Applications. [online]. *Please note: planning application details for Thornset Road Crisis House are no longer available to view.*
- Skapinakis, P., Weich, S., Lewis, G., Singleton, N. and Araya, R. (2006). Socio-Economic Position and Common Mental Disorders: Longitudinal Study in the General Population in the UK. *The British Journal of Psychiatry*, 189, 109-117.
- StataCorp (2017). *Stata Statistical Software: Release 15*. College Station, TX: StataCorp LLC.
- Stickney, S., Yanosky, D., Black, D.R. and Stickney, N.L.. (2012). Socio-demographic variables and perceptual moderators related to mental health stigma. *Journal of Mental Health*, 21(3), 244-256.
- Stiglitz, J.E. et al. (2014). A call for policy change in Europe. *Challenge*, 57(4), 5-17.
- Stuart, H. (2006). Mental illness and employment discrimination. *Current Opinion in Psychiatry*, 19(5), 522-526.
- Taylor-Robinson, D., Whitehead, M. and Barr, B. (2014). Great leap backwards. *British Medical Journal*, 349.
- Teddlie, C. and Tashakkori, A. (1998). *Mixed methodology : combining qualitative and quantitative approaches*, Thousand Oaks, California.: Sage.
- Teddlie, C. and Tashakkori, A. (2009). *Foundations of mixed methods research : integrating quantitative and qualitative approaches in the social and behavioral sciences*, London: Sage.
- The Economist (2008). Undeserving: The poor. [online] Available at: <https://www.economist.com/britain/2008/01/24/undeserving>. Accessed 25/10/2018.

The King's Fund (2017). Is there 'parity of esteem' between mental and physical health? [online] Available at <https://www.kingsfund.org.uk/publications/articles/big-election-questions-parity-mental-physical-health>. Accessed 03/04/2018.

The Star (2012). *Sheffield mental health crisis house plans spark alarm*. [online] Available at: <https://www.thestar.co.uk/news/health/sheffield-mental-health-crisis-house-plans-spark-alarm-1-5220145>. Accessed 30/08/2018.

The World Bank (2016). *Measuring Inequality*. [online] Available at: <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPA/0,,contentMDK:20238991~menuPK:492138~pagePK:148956~piPK:216618~theSitePK:430367,00.html>. Accessed 03/2016.

Thoits, P. (2011). Resisting the Stigma of Mental Illness. *Social Psychology Quarterly*, 74(1), 6-28.

Thornicroft, G. (2006). *Shunned : discrimination against people with mental illness*, Oxford: Oxford University Press.

Thornicroft, G., Evans-Lacko, S. and Henderson, C. (2013). Chapter 11: Stigma and Discrimination. In Davies, S.C. *Annual Report of the Chief Medical Officer 2013, Public Health Priorities: Investing in the Evidence*. London: Department of Health (2014).

Thornicroft, G., et al. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *The Lancet*, 387 (10023), 1123-1132.

TNS Opinion and Social (2010). *Annexes to Special Eurobarometer 345: Mental Health*. [online] Available at: <http://ec.europa.eu/commfrontoffice/publicopinion/index.cfm/Survey/getSurveyDetail/yearFrom/2010/yearTo/2010/surveyKy/898>. Accessed 10/2018

Tyler, I. and Slater, T. (2018). Rethinking the sociology of stigma. *The Sociological Review*, 66(4), 721-743.

Twine, F. (1994). *Citizenship and Social Rights: The interdependence of self and society*. London: Sage Publications Ltd.

Twisk, J.W.R. (2006). *Applied multilevel analysis*. Cambridge: Cambridge University Press.

United Nations Convention on the Rights of Persons with Disabilities (2016). *Inquiry concerning the United Kingdom of Great Britain and Northern Ireland carried out by the Committee under Article 6 of the Optional Protocol to the Convention*. [online] Available at: [www.ohchr.org/Documents/HRBodies/CRPD/CRPD.C.15.R.2.Rev.1-ENG.doc](http://www.ohchr.org/Documents/HRBodies/CRPD/CRPD.C.15.R.2.Rev.1-ENG.doc). Accessed 09/11/2016.

Vassenden, A. and Lie, T. (2013). Telling Others How You Live—Refining Goffman's Stigma Theory Through an Analysis of Housing Strugglers in a Homeowner Nation. *Symbolic Interaction*, 36(1), 78-98.

Voas, D. (2014). Towards a sociology of attitudes. *Sociological Research Online*, 19(1), 1-13.

Wang, C., Caminada, K. and Goudswaard, K. (2012). The redistributive effect of social transfer programmes and taxes: A decomposition across countries. *International Social Security Review*, 65(3), 27-48.

Watters, C. (2012). Chapter 2: Mental health and illness as human rights issues: Philosophical, historical, and social perspectives and controversies. In Dudley, M., Silove, D. and Gale, F. Eds. (2012). *Mental Health and Human Rights*. Oxford: Oxford University Press.

Weekes-Bernard, D. (2017). *Poverty and Ethnicity in the Labour Market*. Joseph Rowntree Foundation.

Weich, S. and Lewis, G. (1998). Poverty, unemployment, and common mental disorders: Population based cohort study. *British Medical Journal*, 317(7151), 115-119.

Welfare Reform Act (2012). London: the Stationary Office.

Whiteford, H. A., Ferrari, A.J., Degenhardt, L., Feigin, V. and Vos, T. (2015). The global burden of mental, neurological and substance use disorders: an analysis from the Global Burden of Disease Study 2010. *PloS one*, 10(2), e0116820.

Wilkinson, R. G. and Pickett, K. (2018). *The inner level : how more equal societies reduce stress, restore sanity and improve everybody's well-being*. London: Allen Lane.

Wong, Y.L. and Solomon, P. (2002). Community Integration of Persons with Psychiatric Disabilities in Supportive Independent Housing: A Conceptual Model and Methodological Considerations. *Mental Health Services Research*, 4(1), 13-28.

Wood, L., Birtel, M., Alsawy, S., Pyle, M. and Morrison, A. (2014). Public perceptions of stigma towards people with schizophrenia, depression and anxiety. *Psychiatry Research*, 220(1-2), 604-608.

World Health Organisation (2013). *Mental Health Action Plan 2013-2020*. [online] Available at: [http://www.who.int/mental\\_health/publications/action\\_plan/en/](http://www.who.int/mental_health/publications/action_plan/en/). Accessed 10/2017.

World Health Organisation (2014). *Social Determinants of Mental Health*. [online] Available at: [http://www.who.int/mental\\_health/publications/gulbenkian\\_paper\\_social\\_determinants\\_of\\_mental\\_health/en/](http://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/). Accessed 09/2018.

World Health Organisation (2018). *Mental health: Project atlas*. [online] Available at: [http://www.who.int/mental\\_health/evidence/atlas/mnh/en/](http://www.who.int/mental_health/evidence/atlas/mnh/en/). Accessed 01/2018

Yang, L.H. et al. (2014). "What matters most:" A cultural mechanism moderating structural vulnerability and moral experience of mental illness stigma. *Social Science and Medicine*, 103, 84-93.

Yanos, P. T. (2007). Beyond "Landscapes of Despair": The need for new research on the urban environment, sprawl, and the community integration of persons with severe mental illness. *Health and Place*, 13(3), 672-676.

Zachariadis, M., Scott, S. and Barrett, M. (2013). Methodological Implications of Critical Realism for Mixed-Methods Research. *MIS Quarterly*, 37(3), 855-879.

Zimmerman, F. J. and Katon, W. (2005). Socioeconomic status, depression disparities, and financial strain: what lies behind the income-depression relationship? *Health Economics*, 14(12), 1197-1215.

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